

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 68-11501

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD THOMAS KELLY

2. DATE AND HOUR OF DEATH

Nov. 14, 1968 10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44

Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND

B. COUNTY

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

610 E. 41st STREET

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

6/2/12

9. AGE (In years lost birthday)

56

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Assistant Director Contractor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

EDWARD T. KELLY

14. MOTHER'S MAIDEN NAME

MARGARET SULLIVAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

CLARA KELLY (WIFE) Same

18. 3719 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Acute Necrotizing Pancreatitis

(B) DUE TO, OR AS A CONSEQUENCE OF:

Cirrhosis of Liver

(C) _____

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/14 19 68 to 11/14 19 68, that (I) (we) last saw the deceased alive on 11/14 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

W. H. Caldwell

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/14/68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

DEGREE

Union Memorial Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/18/68

24C. NAME OF CEMETERY or CREMATORY

St. Stanislaus Cemetery

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

25A. DATE RECEIVED

NOV 18 1968

25B. NAME OF REGISTRAR

Robert E. Kelly

25C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto. St.

ADDRESS

Acid-Nectaries (Linn.)
Growth of A. v. v.

27

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) LOUIS ALEXANDER SCHROEDER				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 13 68 5:15 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6600 Danville Ave.				3. DATE PRONOUNCED DEAD Month Day Year Hour November 13, 1968 5:15 a.m.			
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Nov. 13, 1909				10. AGE (In years last birthday) 59		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF U.S.A.				13. FATHER'S NAME George M. Schroeder			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tractor operator				14B. KIND OF BUSINESS OR INDUSTRY Steel			
15. MOTHER'S MAIDEN NAME Louisa Zeller				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. 213-07-3897				18. INFORMANT ADDRESS Mrs. Jennie Schroeder, 6600 Danville Ave.			
19. CAUSE OF DEATH 15-318 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinoma of the colon ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) No							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 13, 1968							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/16/68		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Colgate, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md.		ADDRESS	

VALLEY COLLEGE

WILSON

1904

WILSON

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT
68-11503 CERTIFICATE OF DEATH

REG. NO. 68-11503

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BANTZ, JR HENRY H.		NOVEMBER 15, 1968 11:15A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
40 ST. AGNES HOSPITAL				MARYLAND Baltimore 53-00	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER	
				6307 FREDERICK RD. 21228	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	04/28/80	88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED		MILLER CO.		MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
U.S.A.		HENRY BANTZ, SR			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
ANNIE BARRETT BANTZ		NONE			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
213-05-0224		ST. AGNES HOSPITAL RECORDS			
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CARDIAC ARREST.			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Congestive Heart failure			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		A-S. eu D			
		(C) _____			
19. 433.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Bening Prostatic Hypertrophy			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 9 1968 to NOVEMBER 15 1968, that (I) (we) last saw the deceased alive on NOVEMBER 15 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Alexander Cruzia				11/15/68	
23C. PHYSICIAN'S NAME (M.D.)				23D. ADDRESS	
A. MEJIA, M.D..				BALTO, MD 21229	
				ST. AGNES HOSP; CATON & WILKENS AVES.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11/18/68		Loudon PK. Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 18 1968		Robert E. Jackson		C S MacNabb	
				ADDRESS	
				301 Frederick Rd	

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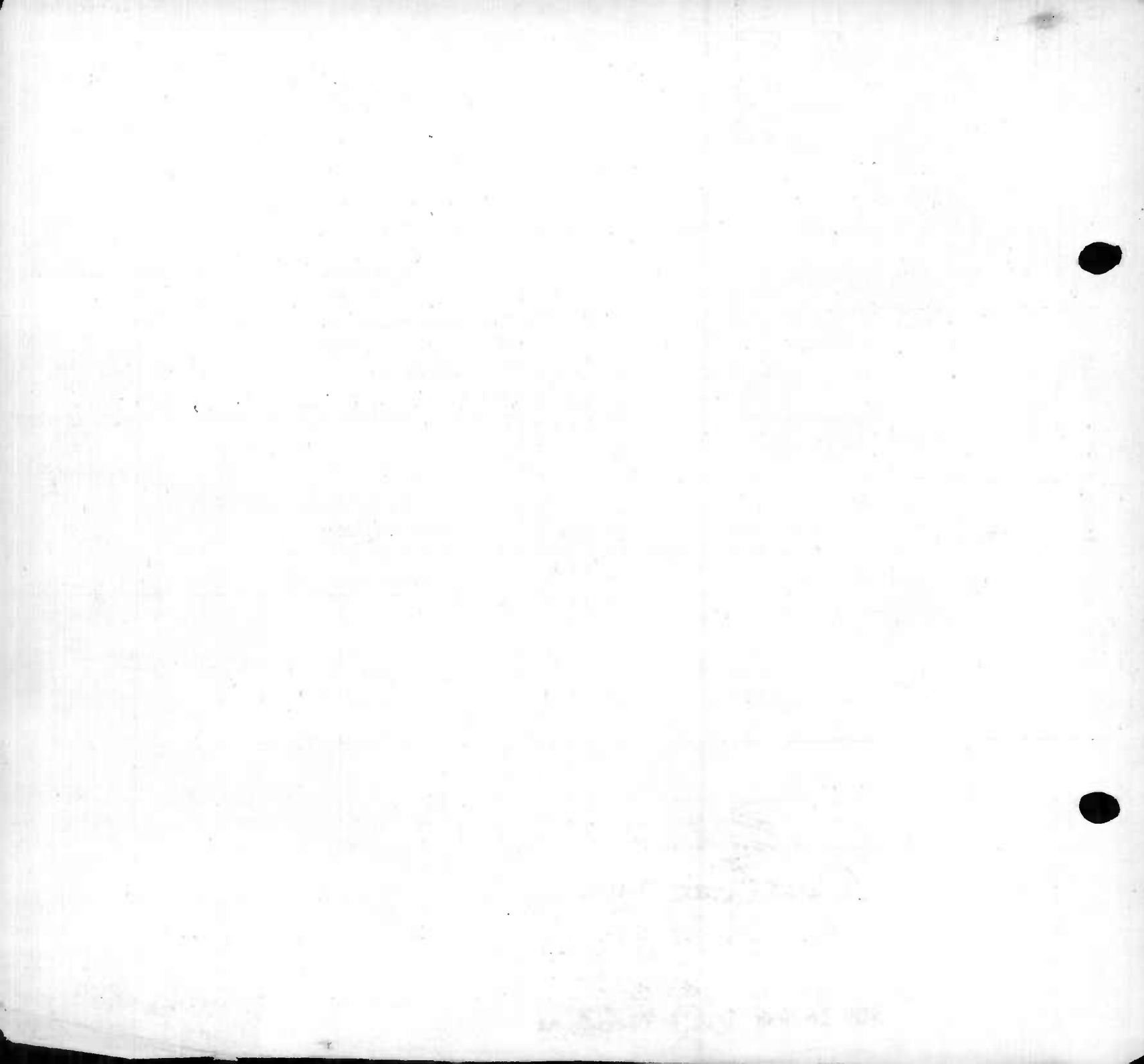
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11504 CERTIFICATE OF DEATH

REG. NO. 68-11504

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Hazel Ellen Perkins		Nov. 14, 1968 11:55 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
US Public Health Service Hospital 3100 Wyman Pk. Drive 2X				Va. C. CITY OR TOWN Honaker D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Rt. 2 Box 49	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	W		1/1/13	55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Va. USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Henry Dye			Nettie Miller		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Records- US PHS Hospital, Balto, Md.	
18. 284X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia (B) Pancytopenia DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal Days 5	
292.4 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (AP) (PM)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Oct. 24, 1968 to Nov. 14, 1968, that (1) (we) last saw the deceased alive on Nov. 14, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter F. Oster				23B. DATE SIGNED 11/14/68	
23C. PHYSICIAN'S NAME (Type) Walter F. Oster, Surgeon (R)				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11-17-68		FAMILY CEM.	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 18 1968		Robert E. Johnson		John W. Weber Sons Inc 401 S. CHESTER ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11505

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11505

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Florence M Mueller

2. DATE AND HOUR OF DEATH

Nov 13 1968 7 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

The Wesley Home
2211 W Rogers Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2211 W Rogers Ave

5. SEX

Female White

6. RACE

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

March 19 1881 87

9. AGE (In years
last birthday)

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George C Mueller

14. MOTHER'S MAIDEN NAME

Sallie P Bender

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220 05 8997A

17. INFORMANT

The Wesley Home 2211 W Rogers Ave

ADDRESS

18.

412.4 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED
While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 18 1966 to November 13 1968
that (I) (we) last saw the deceased alive on 12/November 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John W Barnaby

DEGREE

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

Dr. John W Barnaby

DEGREE

23D. ADDRESS

1531 E. North Ave Bldg Md

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-16-68

24C. NAME OF CEMETERY or CREMATORY

Woodlawn Cem

24D. LOCATION

Woodlawn, Bldg Co, Md

25A. DATE RECEIVED BY HEALTH DEPT

NOV 18 1968

25B. NAME OF REGISTRAR

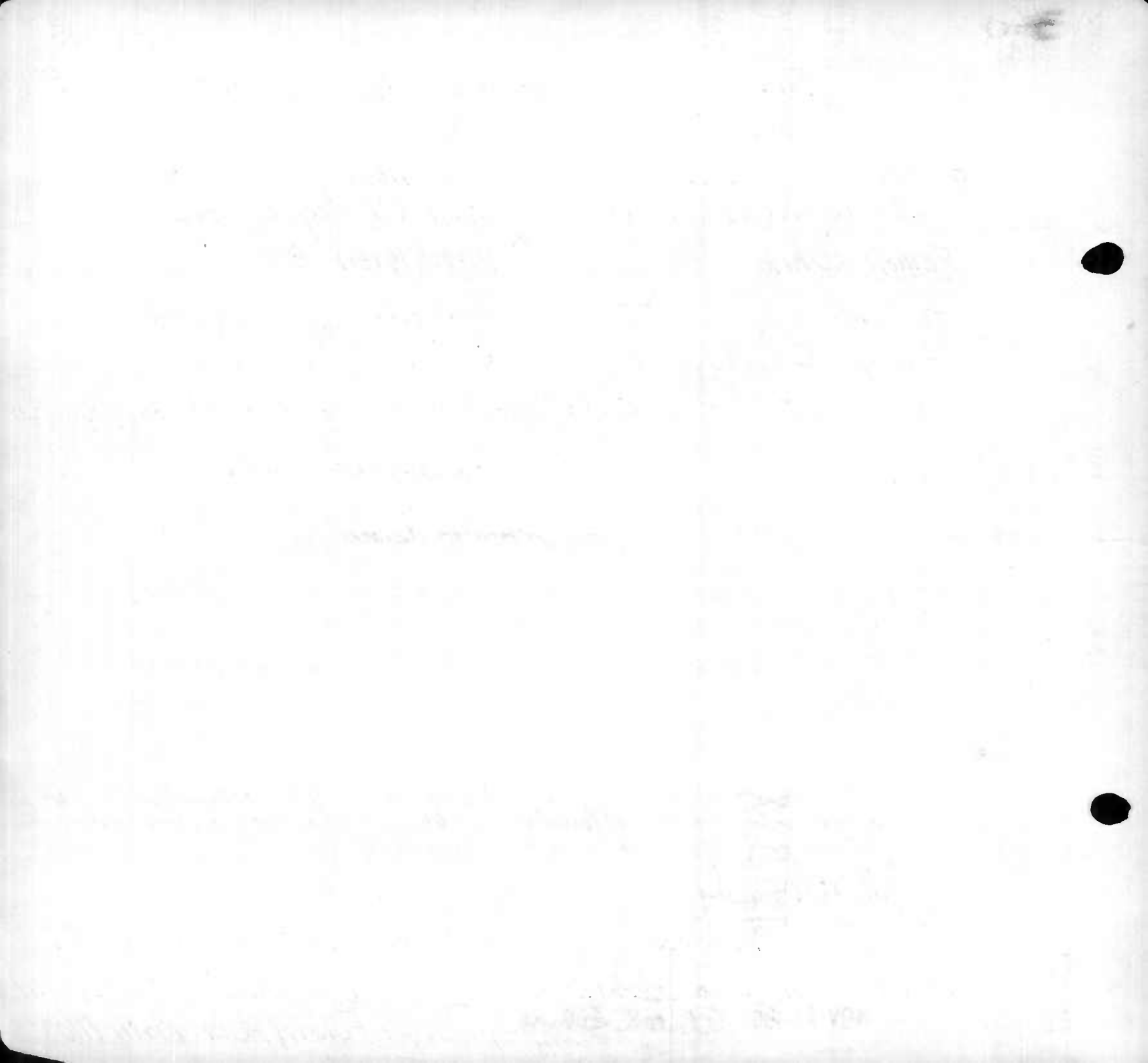
Robert E. Tachy

25C. FUNERAL DIRECTOR

Burger Funeral Home Bldg Md

ADDRESS

Burger Funeral Home Bldg Md



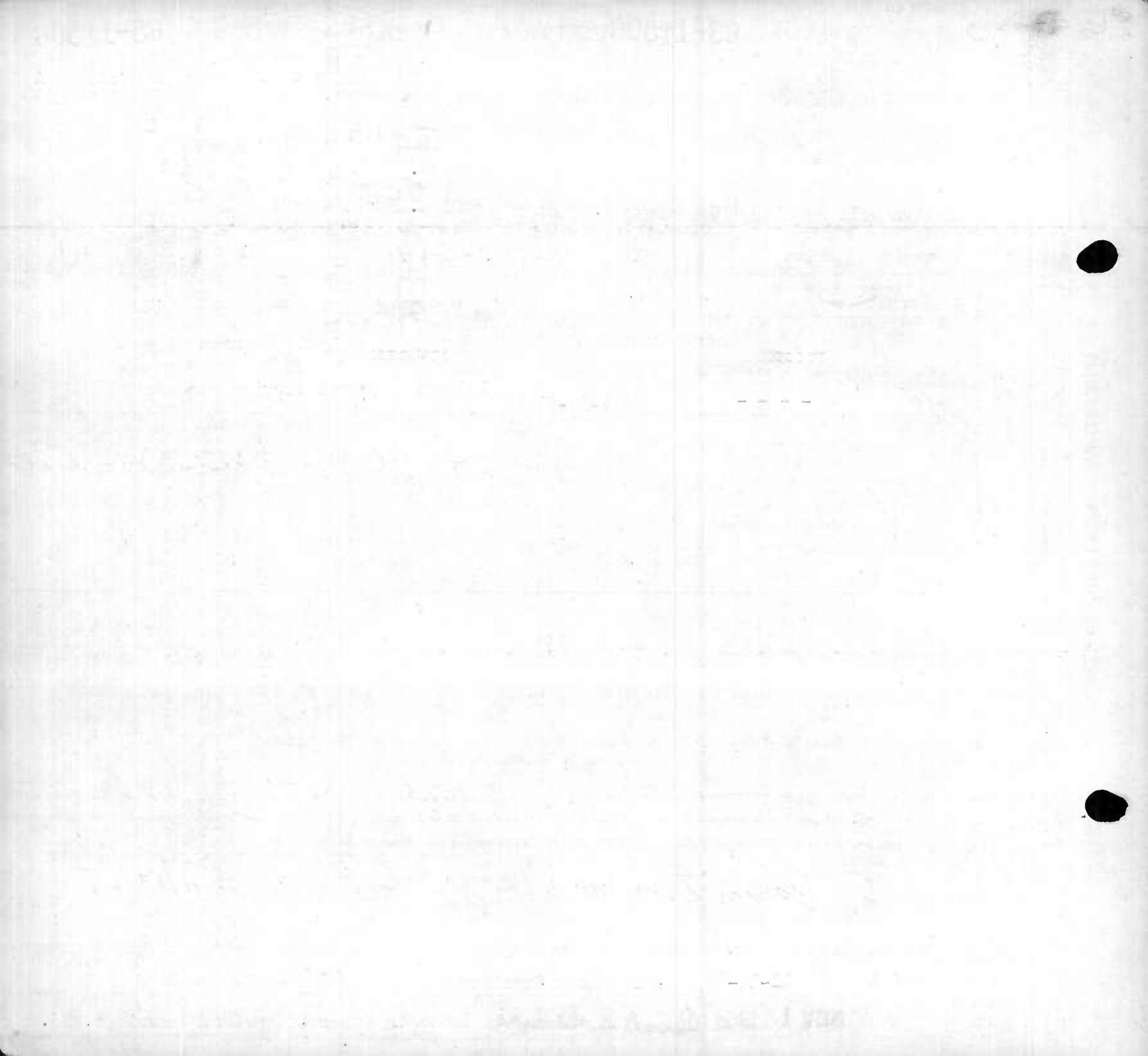
FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT 68-11506 CERTIFICATE OF DEATH

REG. NO. 68-11506

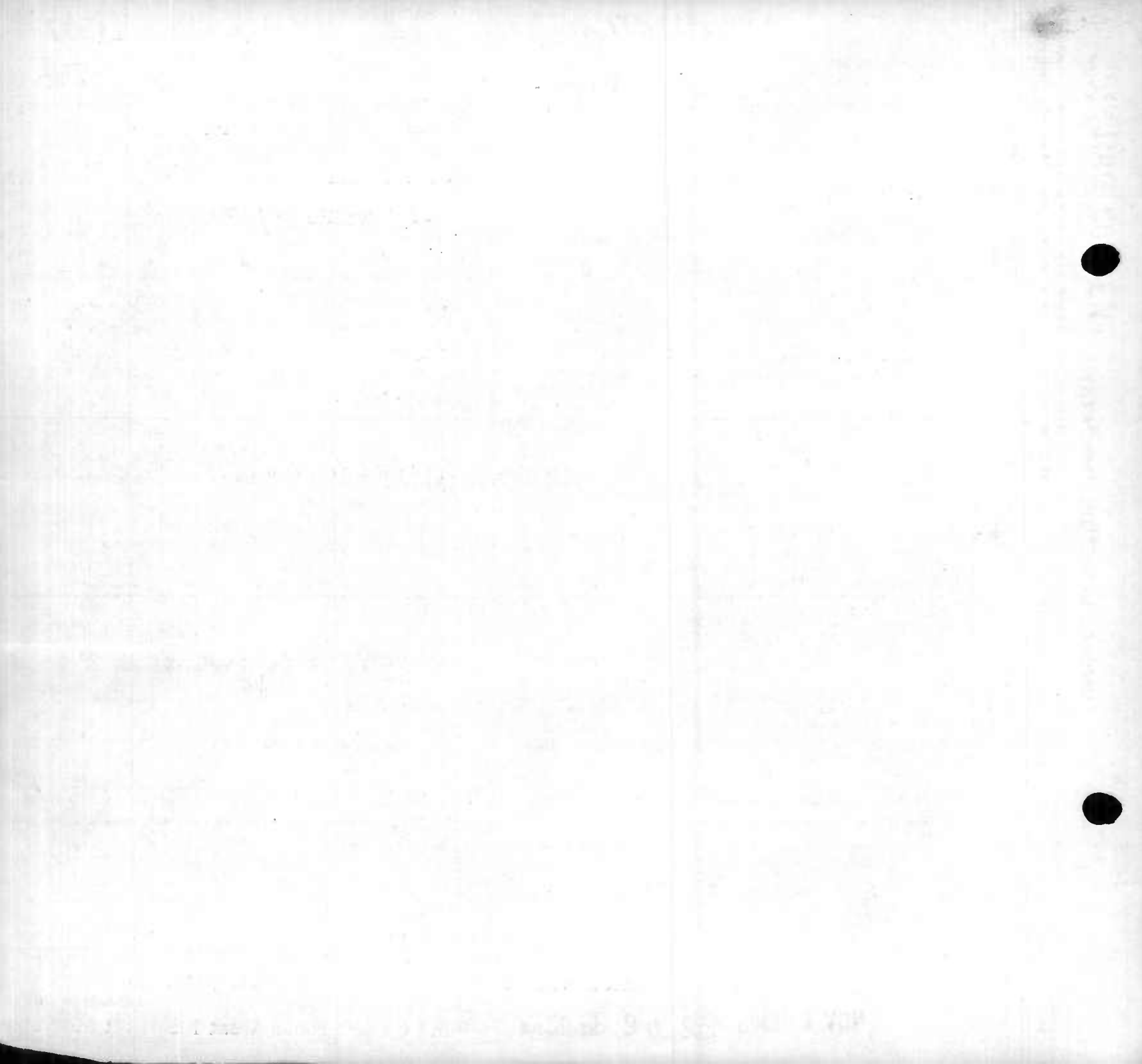
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Ada Edgar		2. DATE AND HOUR OF DEATH 11-11-68 7:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto.		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing & Convalescent Center		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 3001 W. North Avenue	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-1897	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown Henry Renshaw		14. MOTHER'S MAIDEN NAME Unknown Lydia Johnson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-32-3381		17. INFORMANT ADDRESS LeCompte Funeral Service records	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) AS HD, Myoc. Infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: AS HD, Myoc. Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 5 1968 to Nov. 11 1968 , that (I) (we) lost saw the deceased alive on Nov. 9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen Tans, MD		23B. DATE SIGNED 11/13/68		23C. PHYSICIAN'S NAME (Type) Stephen Tans, MD	
23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-14-68		24C. NAME OF CEMETERY or CREMATORY Greenlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Cambridge, Maryland					
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11507 4
BIRTH NO. 68-21494		68-11507 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Baby Girl of Mary L. Seltzer		2. DATE AND HOUR OF DEATH 11/10/68 6:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Howard Co. 63-00 C. CITY OR TOWN Marriotsville D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Marriotsville Rd		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/68	9. AGE (In years last birthday) 14 30
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Bernard F. Seltzer		
14. MOTHER'S MAIDEN NAME Mary Lou Seltzer		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. —		17. INFORMANT Parents + Hospital Record ADDRESS		
18. 038.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Probable Sepsis DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. 053.4 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (this hospital) attended the deceased from 4:14 A.M. Nov 10 1968 to 6:45 P.M. Nov 10 1968, that (we) last saw the deceased alive on Nov 10 1968 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.				
23A. SIGNATURE Douglas S. Kerr M.D. DEGREE		23B. DATE SIGNED 11/10/68		23C. PHYSICIAN'S NAME (Type) Douglas S. Kerr M.D. DEGREE
23D. ADDRESS Sinai Hospital, Baltimore, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/13/68	24C. NAME OF CEMETERY OR CREMATORY Meadowridge	24D. LOCATION (City, town, or county) (State) Howard County, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968	25B. NAME OF REGISTRAR Robert E. Jackson	25C. FUNERAL DIRECTOR ADDRESS Wm Cook-Brooks West Inc Balt Md 2122		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-11508
BIRTH NO.		68-11508		
1. NAME OF DECEASED (Type or Print) HARRIS Pinkerton		2. DATE AND HOUR OF DEATH 11-12-68 4 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 12-06		
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX m 6. RACE W		E. STREET AND NUMBER 3440 N. Charles St.		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-6-05		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN		11. BIRTHPLACE (State or foreign country) U.S.A. NEB		9. AGE (In years last birthday) 63
10B. KIND OF BUSINESS OR INDUSTRY Necktie Co		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HARRY Pinkerton		14. MOTHER'S MAIDEN NAME LAURA Schwartz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 163-10-3622		
17. INFORMANT Edward H. Schaffa		ADDRESS 2440 N. Charles St		
18. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Nutritional Cirrhosis of Liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 53 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 581.0 II		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 581.0 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Sept. 21 19 68 to Nov. 12 19 68 , that (I) (we) last saw the deceased alive on Nov. 12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Chang Shee Chang, M.D.			23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) CHANG-SHEE CHANG, M.D.			23D. ADDRESS Mercy Hospital, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 11/18/68		24C. NAME OF CEMETERY or CREMATORY LODON PARK
24D. LOCATION BALTO, MD		25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		
25B. NAME OF REGISTRAR Robert E. Tisdale		25C. FUNERAL DIRECTOR Paul E. Charney		
25D. ADDRESS 3617 Chestnut Ave				

11/20/68 - operation 10/24/68 -
information via phone - Army Hosp.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 127 79 11 68-11509				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11509	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>GOLDBERG, MORRIS</i>				2. DATE AND HOUR OF DEATH <i>11/14/68 6 AM</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Mo.</i> B. COUNTY <i>Balto Co.</i> <i>53-00</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE LOUIS HOPKINS HOSPITAL</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) <i>3219 N. NORTH BROOK AVE 8</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>5/11/12</i>		9. AGE (In years lost birthday) <i>56</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>AARON GOLDBERG</i>				14. MOTHER'S MAIDEN NAME <i>SARAH</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>214-03-0672</i>		17. INFORMANT <i>MRS PAULINE GOLDBERG</i>		ADDRESS <i>SAME</i>
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Acute Myocardial Infarction</i> DUE TO (B) <i>Coronary Atherosclerosis</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>420.1 II</i>							
19A. DATE OF OPERATION <i>0 NOV 22</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>November 14 1968</i> to <i>November 14 1968</i> , that (I) (we) saw the deceased alive on <i>November 14</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Gottlieb C. Friesinger</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>November 14, 1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>GOTLIEB C. FRIESINGER</i>				23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/15/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arnsle Emmanah City Charn</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 18 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Friesinger</i>		25C. FUNERAL DIRECTOR <i>Sylvan S. Lewis & Son Inc</i>		ADDRESS <i>9610 Reisterstown Rd</i>	

Forwards, please 11/1/52

No.
Barman
3219 N. Normandie St.
2/1/52 26

Le Louis Remy Kasper

M. W.

Barry Hutchinson
Auto Repaired Refactor

No.

No.

No.

November 14 52 Normandie St.
November 14 52

Barry Hutchinson

NOV 18 1952

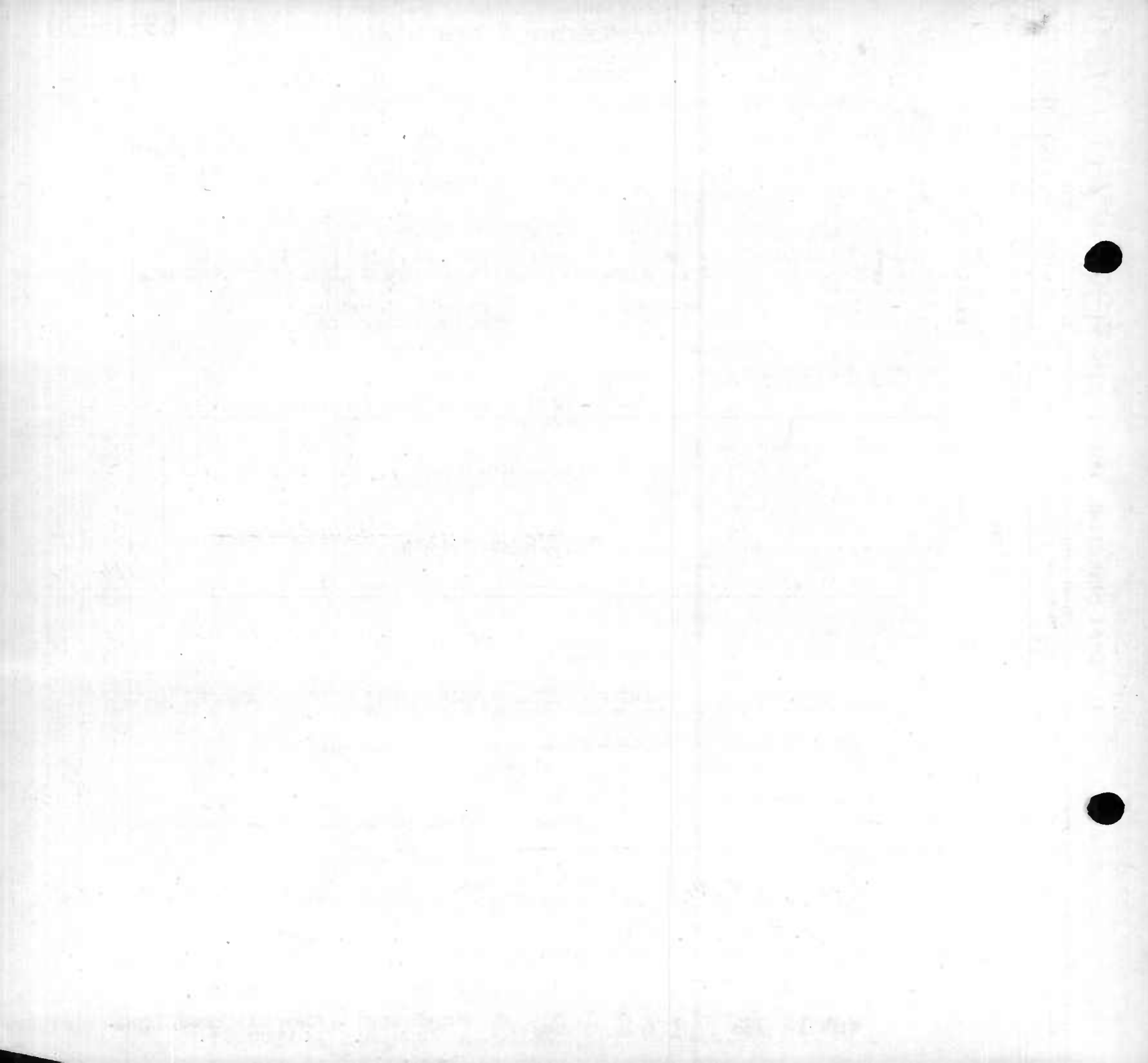
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11510 CERTIFICATE OF DEATH

REG. NO. 68-11510

BIRTH NO.		1. NAME OF DECEASED (Type or Print) RUDOLPH O. BEHOUNEK		2. DATE AND HOUR OF DEATH Nov. 12, 1968 8:30 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md., B. COUNTY 21205		
FULL NAME OF HOSPITAL OR INSTITUTION 00 2406 E. Monument St.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2406 E. Monument St.		
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 11, 1893	9. AGE (In years lost birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret-Tailor		10B. KIND OF BUSINESS OR INDUSTRY Miller-Robinson		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
13. FATHER'S NAME Frank Behounek			14. MOTHER'S MAIDEN NAME Anna Herl		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 216-01-3292		16. SOCIAL SECURITY NO. 216-01-3292		17. INFORMANT Anna Ludwig Behounek, wife, above	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac Insufficiency ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Metastasis Ca - Lung			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) 1964-1968 Arteriosclerosis - generalized		
19. DATE OF OPERATION 163X II			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/17 19 67 to 11/12 19 68 , that (I) (we) last saw the deceased alive on 11/12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Louis C. Klimes			23B. DATE SIGNED 11/13/68		23C. PHYSICIAN'S NAME (Type) Dr. Louis C. Klimes
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 11/15/68		24C. NAME of CEMETERY or CREMATORY Bohemian National Cem.
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968			25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.
					ADDRESS 2601 E. Madison St.



FUNERAL DIRECTOR: IMPORTANT 12 68

OSL b

This certificate must be approved by the chief medical examiner or his assistant, if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased, prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68-11511 CERTIFICATE OF DEATH

REG. NO.

68-11511

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Peter

LUTHER WELLS

2. DATE AND HOUR OF DEATH

Nov. 12 1968

9 31 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

8. COUNTY

MARYLAND

BALTIMORE CITY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

BALTIMORE

YES ☒NO ☐

E. STREET AND NUMBER

3720 Bonview Avenue

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3-6-91

9. AGE (In years lost birthday)

77

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Conductor

10B. KIND OF BUSINESS OR INDUSTRY

B & O R. R.

11. BIRTHPLACE (State or foreign country)

Randolph County, Ind.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

JOHN WELLS

14. MOTHER'S MAIDEN NAME

ELIZABETH DRURY Eurey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

705-05-3739

17. INFORMANT

ADDRESS

Ethel Haines Wells, wife, above

18.

162, I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

RESPIRATORY ARREST

(B)

DUE TO, OR AS A CONSEQUENCE OF:

METASTATIC LUNG CANCER 2 YEARS

(C)

MEDICAL CERTIFICATION

165-X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined)

21B. PLACE OF INJURY (e.g., in or about home, form, lactory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from Oct 28 19 68 to Nov. 12 19 68, that (1) (we) last saw the deceased alive on Nov. 12 19 68 and that in (1) (our) opinion death occurred on the date

and hour and from the causes stated above. (1) (We) (did) (did nat) view the body after death.

23A. SIGNATURE

John R. Sobotka MD

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

11/12/68

23C. PHYSICIAN'S NAME (Type)

JOHN R. SOBOTKA MD

23D. ADDRESS

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/16/68

24C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D IN HEALTH DEPT

NOV 18 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Schimunek Funeral Home Inc.

ADDRESS

3331 Brehms Lane

54-10

120



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

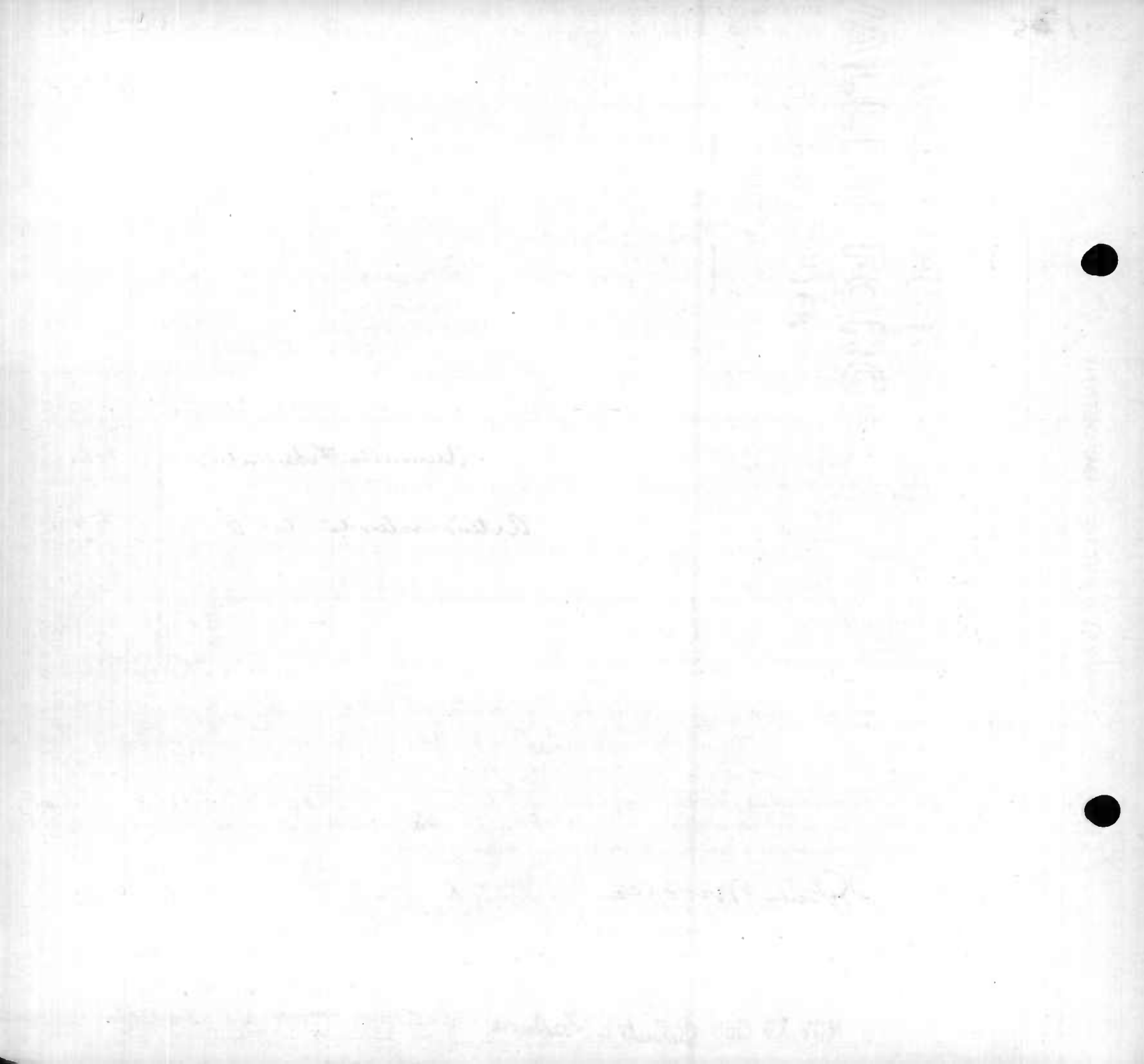
68-11512

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11512

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JAMES McDONALD SLOCUM, SR.		Nov. 13, 1968 6130 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 33 79 Johns Hopkins Hospital (DOA)				A. STATE Md. 21213	
				B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3422 Clifftmont Ave.	
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH June 3, 1897	9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger		10B. KIND OF BUSINESS OR INDUSTRY Truck Rental Corp.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME John T. Slocum				14. MOTHER'S MAIDEN NAME Bertha Schonhof	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-28-2681		17. INFORMANT Margaret Schmitt Slocum, wife, above	
				ADDRESS	
				Margaret Schmitt Slocum, wife, above	
18. 412.41 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Antecubital Fibrillation			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Arterio-sclerosis C.V.D.			5 yrs.
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
43311 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 1960 to 11-8 1968, that (I) (we) last saw the deceased alive on 11-8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Duer Moores				23B. DATE SIGNED 11-14-68	
23C. PHYSICIAN'S NAME (Type) Dr. J. Duer Moores				23D. ADDRESS 3105 Belair Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/16/68		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. J. J. J.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
				Marie Whited				Nov. 14, 1968 11 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CERTIFICATE AMENDED 12-2-68 90 House-in-the-Pines-Belvedere								A. STATE Md.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)								B. COUNTY Balto.			
C. CITY OR TOWN								D. INSIDE CITY LIMITS?			
6816 Starbridge Dr.								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
Fem.		Cauc.				12-8-1883		84			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Housewife				Home				Ohio			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
Martin Keuchel				Laure Backert				U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				152-05-2609				William Whited - Same as above			
18. CAUSE OF DEATH								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident - 24 hrs. a. Atherosclerotic Cerebral Vascular Disease - years b. Hypertensive C.V.D. (B) DUE TO, OR AS A CONSEQUENCE OF: c. Heart - Enlarged (Atherosclerotic) (C) a. aortic dissection (Atherosclerotic) b. cardiac thrombosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).								20A. AUTOPSY? (Yes or No)			
19A. DATE OF OPERATION								19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)								21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>65</u> to <u>Nov. 14</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov. 14</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Bernard J. Cohen M.D.								Nov. 14, 1968		Bernard J. Cohen	
23D. ADDRESS								23E. NAME OF CEMETERY or CREMATORY		23F. LOCATION (City, town, or county) (State)	
Marylander Apt., Balto., Md.								Woodlawn Cem.		New York, N.Y.	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial				11-16-1968		Woodlawn Cem.		New York, N.Y.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
NOV 18 1968				Robert E. Johnson				Wm. Cook Brooks, Inc. Balto., Md. 21202			

Letter from Son William B. Whited
12-2-68 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11514 CERTIFICATE OF DEATH

REG. NO.

68-11514

BIRTH NO.		1. NAME OF DECEASED (Type or Print) TIMOTHY J. WIMPLING SR.		2. DATE AND HOUR OF DEATH NOV. 15, 1968 7:15A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) N. CHARLES GENERAL HOSPITAL 49		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-42 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1504 PATAPSCO			
5. SEX M.	6. RACE Demian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-21	9. AGE (In years last birthday) 45	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRAWBRIDGE OPER.		10B. KIND OF BUSINESS OR INDUSTRY MARINE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harry J. Wimpling		14. MOTHER'S MAIDEN NAME Sadie Reed	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes # 2		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record ADDRESS	
18. 230.7 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) acute myocardial infarct, heart		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe atherosclerosis, coronary art. (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes m. (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOV. 15 1968 to NOV. 15 1968 , that (I) (we) lost saw the deceased alive on NOV. 15 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. Tanguilig, M.D.		23B. DATE SIGNED NOV. 15, 1968		23C. PHYSICIAN'S NAME (Type) L. TANGUILIG M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11 18 68		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) Brooklyn, A. A. Co. Md.		24E. FUNERAL DIRECTOR Mc Cully		24F. ADDRESS 130 E. Fort Ave	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Tanguilig		25C. FUNERAL DIRECTOR Mc Cully	

TIME 11:00 AM

REPORT FROM THE

REPORT

REPORT

REPORT

REPORT

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REPORT

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FUNERAL DIRECTOR: IMPORTANT

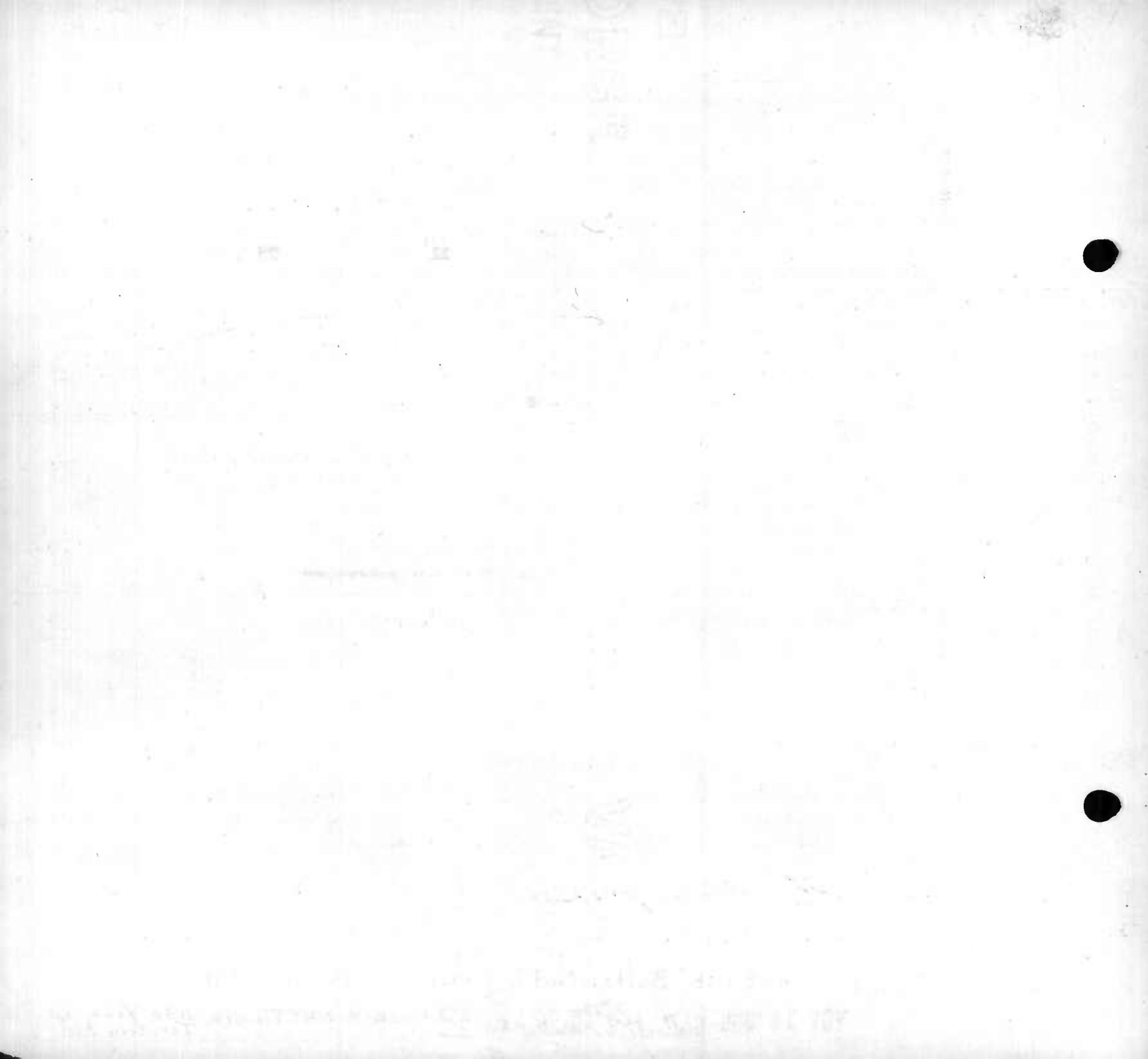
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11515 CERTIFICATE OF DEATH

REG. NO. 10

68-11515

BIRTH NO.		1. NAME OF DECEASED (Type or Print) William Dale Fowler		2. DATE AND HOUR OF DEATH Nov. 13, 1968 10:40 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Park Drive		C. CITY OR TOWN Cockeysville		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 15 Warren Lodge Rd.					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/10	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY USMC		11. BIRTHPLACE (State or foreign country) NC	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George W. Fowler			14. MOTHER'S MAIDEN NAME Octavia Lane		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USMC 1930-1955		16. SOCIAL SECURITY NO. 554-38-6881		17. INFORMANT Records- US PHS Hospital, Balto, Md.	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Renal cell carcinoma, right kidney ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, 180X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Metastatic carcinoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Mos.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1968 to Nov. 13, 1968 , that (I) (we) last saw the deceased alive on Nov. 13, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. D. Bellamy, Sr. Surgeon				23B. DATE SIGNED 11/14/68	
23C. PHYSICIAN'S NAME (Type) Murlyn D. Bellamy, Sr. Surgeon		23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-18-1968		24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l. Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Rd. Towson, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11516

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11516

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) WILLIAM PETER MONG

2. DATE AND HOUR OF DEATH

11/15/68

8 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

3604 MOHAWK AVE (ANDERSON NURSING HOME)

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

06 04 83

9. AGE (In years
lost birthday)

85

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

COOK

10B. KIND OF BUSINESS OR INDUSTRY

Rest. - Retired

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph Mong

14. MOTHER'S MAIDEN NAME

Harriett Williams

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

18 18 7831

17. INFORMANT BALTO MD 21229

ADDRESS

31 ST AGNES HOSP RECORDS WILKENS & CATO

18. E 8871X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) Fracture R. hip

DUE TO, OR AS A CONSEQUENCE OF:

(C) Complete heart block

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 min

9 days

1 year

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

11/11/68

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Subcap fr. L. femur

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

NOTIFIED

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Nursing home

21C. WHERE DID
INJURY OCCUR?

Nursing home 28-41

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

11 6 68

21E. INJURY OCCURRED

White At
Work ☐Not White
At Work ☒

21F. HOW DID INJURY OCCUR?

UNKNOWN

22. I certify that (I) (this hospital) attended the deceased from 11/06 19 68 to 11/15 19 68

that (X) (we) last saw the deceased alive on 11/15 19 68 and that in (X) (our) opinion death occurred on the date

and hour and from the causes stated above. (X) (we) did (X) (did not) view the body after death.

23A. SIGNATURE

George W. Wharton M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11/15/68

23C. PHYSICIAN'S
NAME (Type)

George W. Wharton M.D.

23D. ADDRESS

St. Agnes Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-18-1968

24C. NAME OF CEMETERY or CREMATORY

Lorraine Park Cem.

24D. LOCATION

Balto. Co., Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 18 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks West. 6212 Balto. Nat'l Pike

ADDRESS

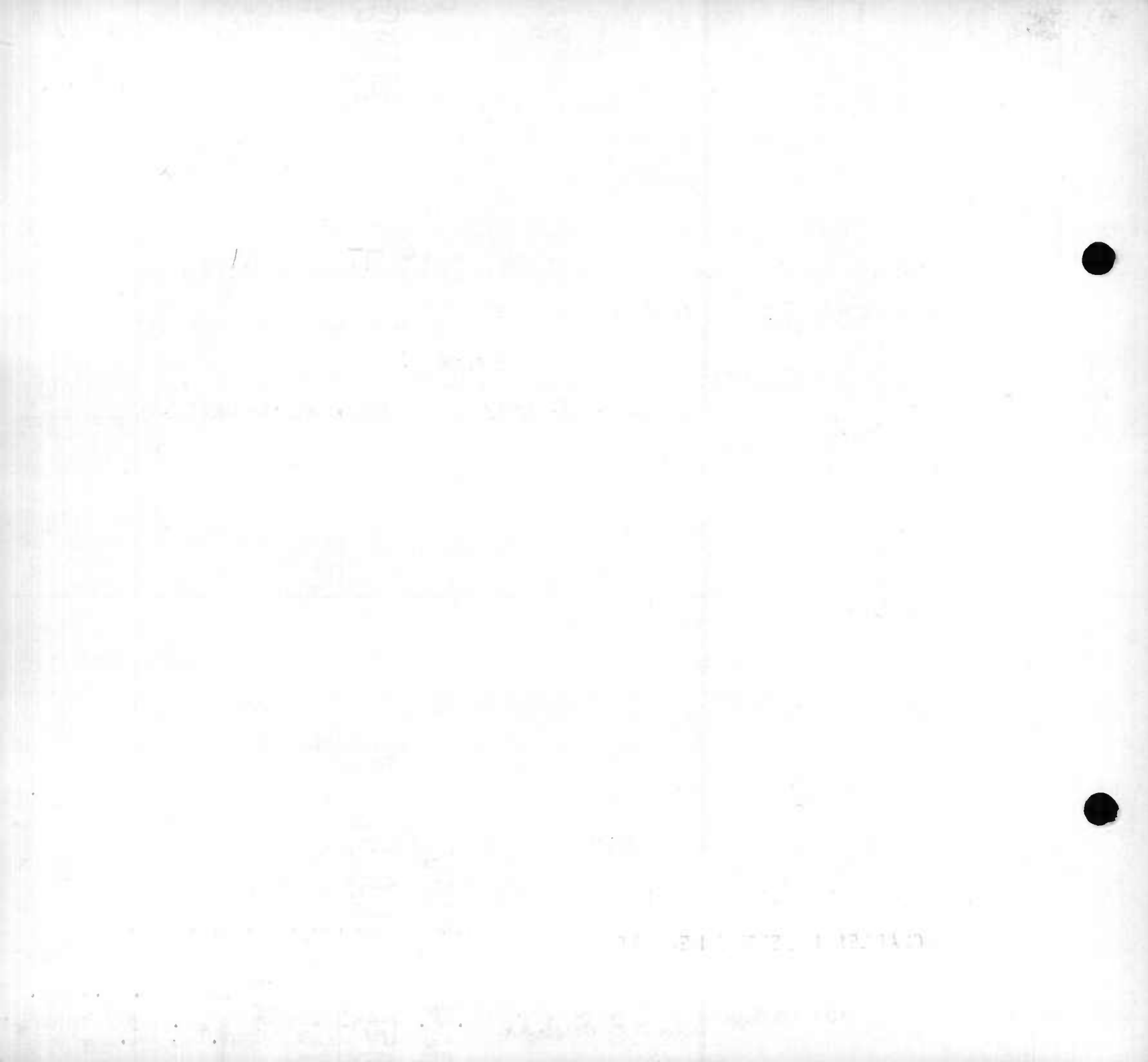
Catonsville Md.



FUNERAL DIRECTOR: IMPORTANT

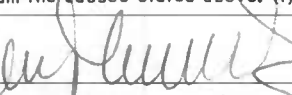
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11517 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11517	
BIRTH NO.			1. NAME OF DECEASED (Type or Print) <u>Nora G. Palmore</u>		
2. DATE AND HOUR OF DEATH <u>Nov. 16, 1968 4:40 P.M.</u>			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>PRINCE GEORGE</u>			FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hosp.</u>		
C. CITY OR TOWN <u>College Park</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			E. STREET AND NUMBER <u>4809 Calvert Rd. 66-00</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/16/77</u>	9. AGE (In years last birthday) <u>91</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME Maryland</u>		
11. BIRTHPLACE (State or foreign country) <u>USA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Charles Harman</u>			14. MOTHER'S MAIDEN NAME <u>Emma Welsh</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>220-48-9799</u>		
17. INFORMANT <u>MRS. HASKIN W. DEE LEY</u>			ADDRESS <u>4300 ROLAND AVE.</u>		
18. <u>441.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Internal blood loss.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Ruptured Abdominal Aortic Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): <u>451X II</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11/16</u> 19 <u>68</u> to <u>11/16</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>11/16</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles Robert Gohen MD</u>			23B. DATE SIGNED <u>11/16/68</u>		Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>CHARLES ROBERT GOHEN MD</u>			23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11/19/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge</u>	24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u>		
25A. DATE REC'D <u>NOV 18 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>	25C. FUNERAL DIRECTOR ADDRESS <u>H. W. Jenkins & Sons Co. 4905 York Rd Balto. 12, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11518
BIRTH NO. 68-11518		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) STOCKLEY, DONALD A.		2. DATE AND HOUR OF DEATH 11/16/68 12:25 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 411 SOUTH WAY		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-21-95	9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (RET.) CLERK		10B. KIND OF BUSINESS OR INDUSTRY BALTO. CITY		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME ALBERT A. STOCKLEY, JR.		12. CITIZEN OF WHAT COUNTRY? AMERICAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-40-5927		17. INFORMANT ADDRESS STELLA P. STOCKLEY (ABOVE)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 13-6-11 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE PARTIAL PYLORIC OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF: (B) POSSIBLE LIVER'S MALIGNANCY DUE TO, OR AS A CONSEQUENCE OF: (C) CARDIAC ARREST.		
19A. DATE OF OPERATION 10-6-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work Work		21F. HOW DID INJURY OCCUR?
22. I certify that the (this hospital) attended the deceased from 11-5-68 to 11-16-68, 1968, that (I) last saw the deceased alive on 11/16 1968 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED 11/16/68		23C. PHYSICIAN'S NAME (Type) LUIS CINTADO MD.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/19/68		24C. NAME OF CEMETERY or CREMATORY Loudon Park
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) (State) Md.		
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

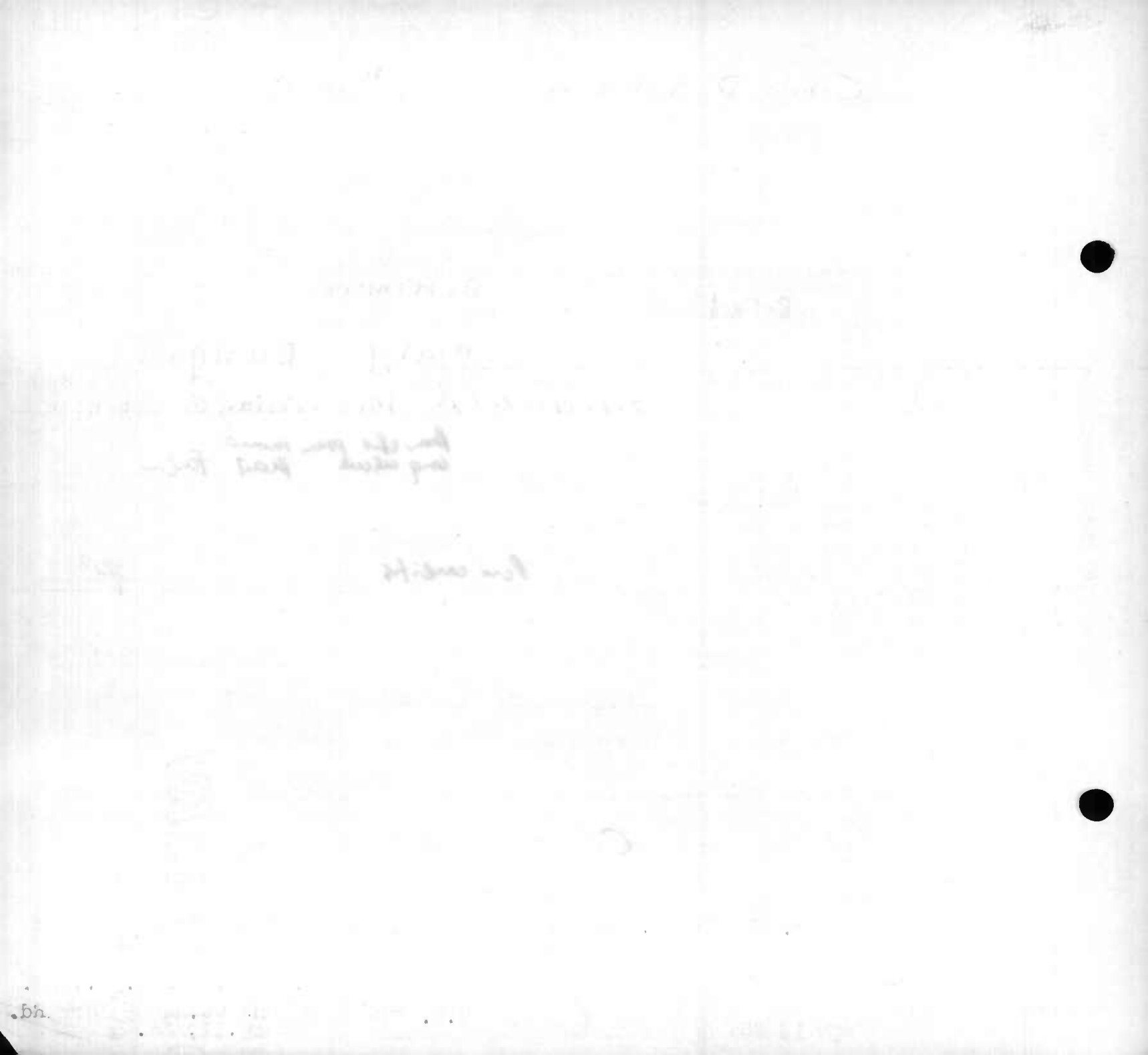
68-11519

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11519

BIRTH NO.		1. NAME OF DECEASED (Type or Print) James D. Robinson		2. DATE AND HOUR OF DEATH 11/16/68 9:30a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY Baltimore		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 248 Apt B Rodgers Forge Rd.		5. SEX M		6. RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/31/89		9. AGE (In years lost birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor Retired Real Estate		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Robinson		14. MOTHER'S MAIDEN NAME Mary Dungan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-01-7356		17. INFORMANT Mrs. Lillian C. Robinson	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 410.9 I Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Am chf. pneumonia long term heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Nov. 11 19 68 to Nov. 16 19 68 , that (I) (we) lost saw the deceased alive on Nov. 16 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Dr. Charles R. Goshen	
23B. DATE SIGNED 11/16/68		23C. PHYSICIAN'S NAME (Type) Dr. Charles R. Goshen		23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/19/68		24C. NAME of CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Rd. Balto. 12, Md.			

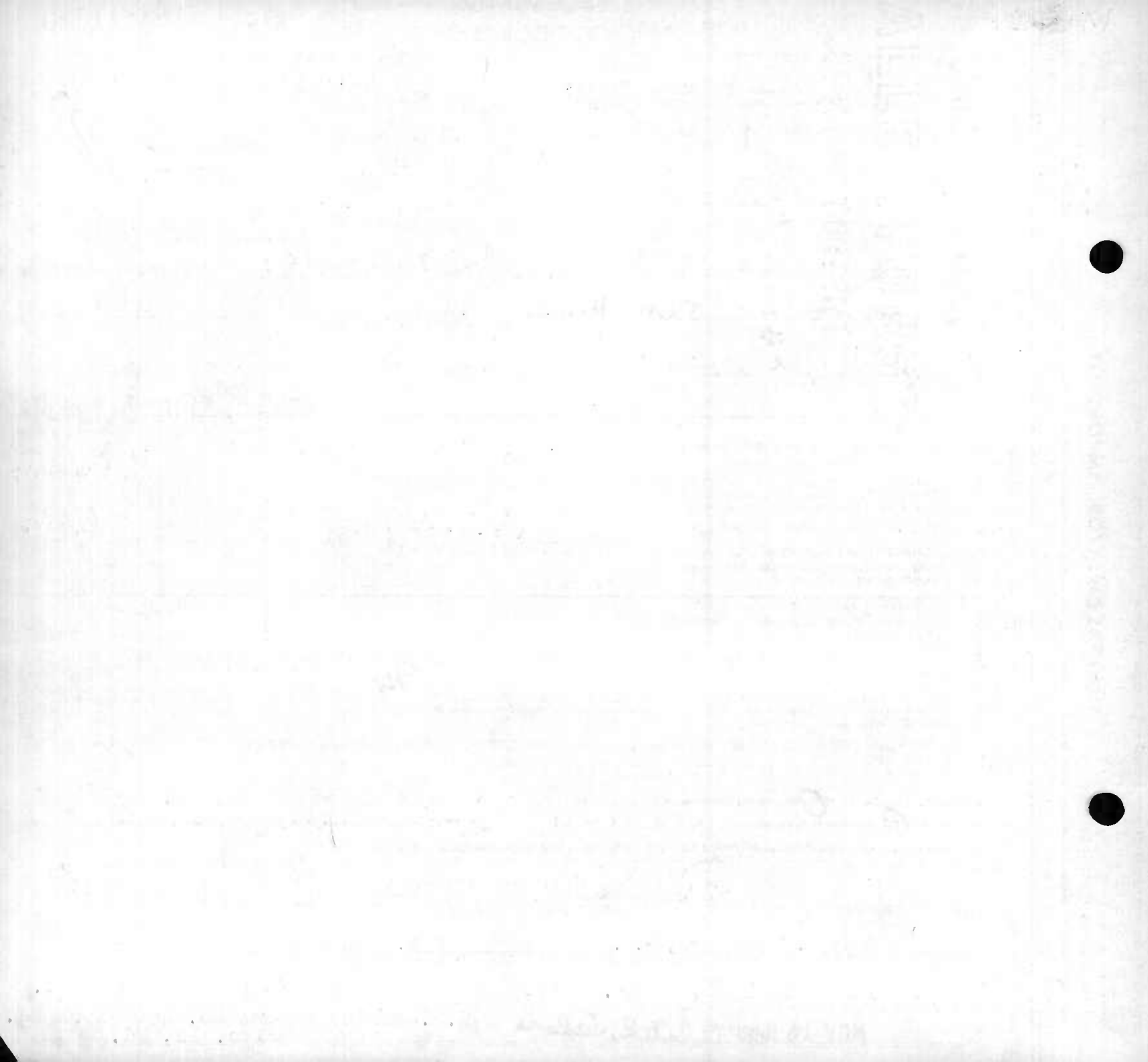


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11520 CERTIFICATE OF DEATH

REG. NO. 68-11520

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Mrs. Rena Skinner miles</u>		2. DATE AND HOUR OF DEATH <u>11-17-68</u> <u>9 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>13-07</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Keswick</u> <u>700 W. 40th St.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17 1864</u>	9. AGE (In years last birthday) <u>104</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William S. Skinner</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Jones</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-54-7800</u>		17. INFORMANT <u>M. S. McTear, RN</u> ADDRESS <u>700 W. 40th St.</u>	
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Vascular Accident</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant and 6 months</u> <u>3 1/2 yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>APRIL 18, 1968</u> to <u>Nov. 17, 1968</u> , that (1) (we) last saw the deceased alive on <u>Nov 17 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Aubrey D. Richardson, M.D.</u> DEGREE				23B. DATE SIGNED <u>18 Nov 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>Aubrey D. Richardson, M.D.</u> DEGREE				23D. ADDRESS <u>700 W. 40th Street</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/19/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
24D. LOCATION <u>Baltimore</u>		24E. (City, town, or county)		24F. (State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 18 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11521 CERTIFICATE OF DEATH

REG. NO.

68-11521

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Luther P. Himler

2. DATE AND HOUR OF DEATH

Nov. 14, 1968

5 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1309 E. Belvedere Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

1309 E. Belvedere Ave.

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

May 24, 1898

9. AGE (In years lost birthday)

70

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired-Ass'T Supervisor Elec. Co.

10B. KIND OF BUSINESS OR INDUSTRY

Balto. Gas &

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Himler

14. MOTHER'S MAIDEN NAME

Elizabeth Engle

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-05-6539

17. INFORMANT

Mrs. Ida A. Himler (Same)

ADDRESS

18. 492X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Coma 2nd to severe respiratory failure

(B) DUE TO, OR AS A CONSEQUENCE OF:

Severe pulmonary emphysema 2nd to pulmonary

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Days

Year

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-26 1965 to 11-14 1968. that (I) (we) lost saw the deceased alive on 11-14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

RK Gundry

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

11-15-68

23C. PHYSICIAN'S NAME (Type)

Dr. Richard K. Gundry

23D. ADDRESS

2 W. University Pkwy.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/18/1968

24C. NAME OF CEMETERY or CREMATORY

Parkwood

24D. LOCATION

Parkville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

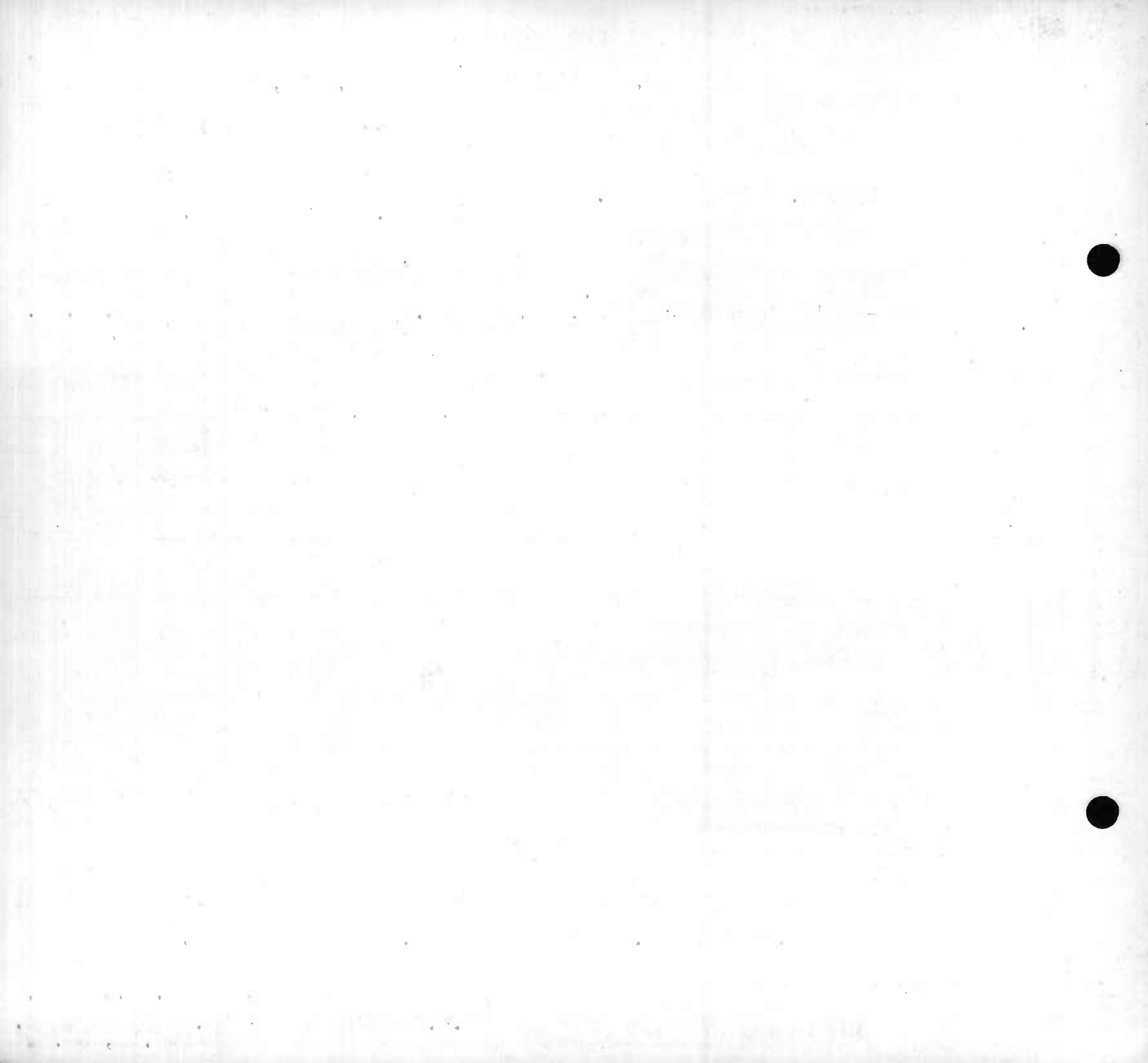
NOV 18 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

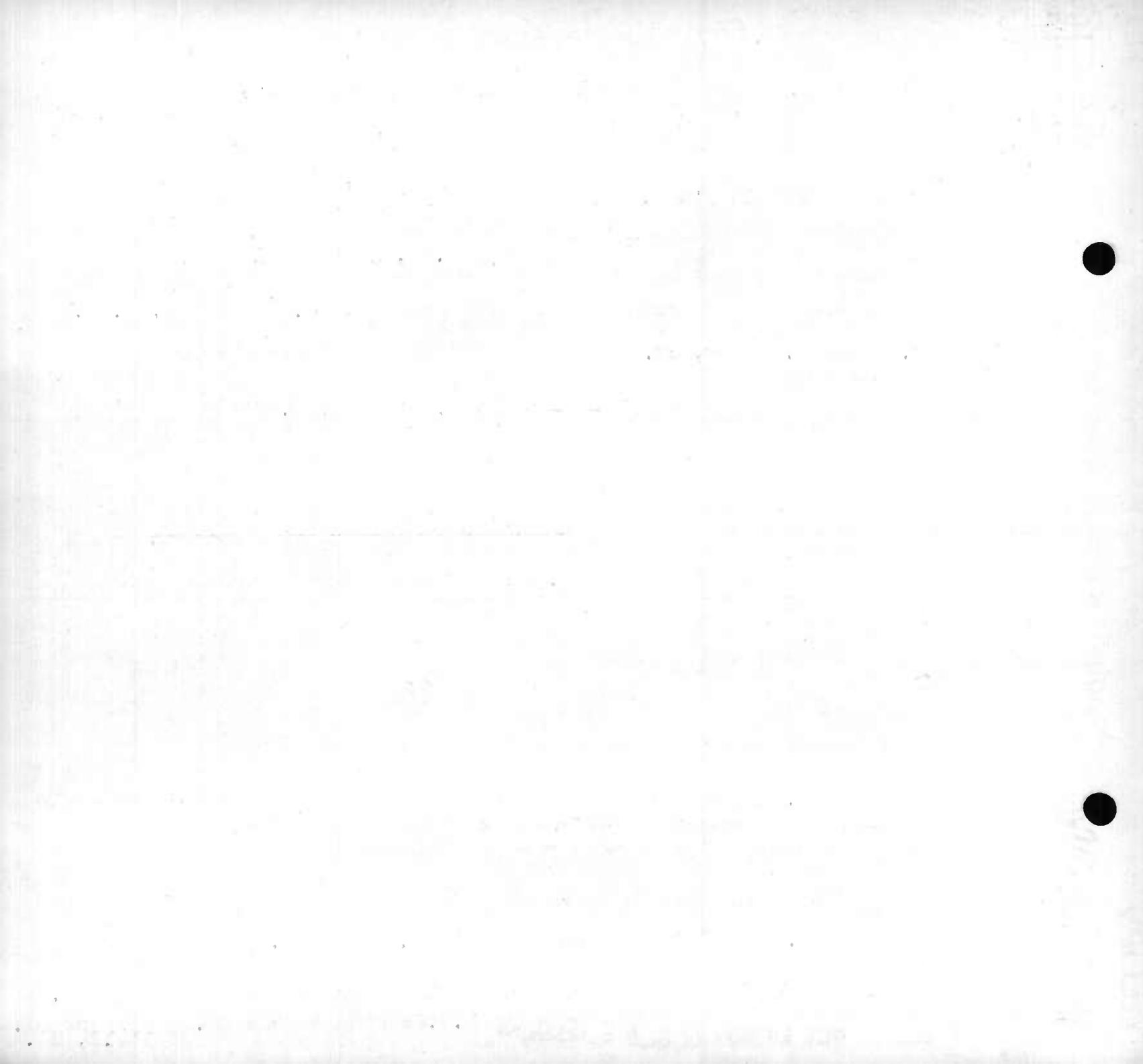
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11522
BIRTH NO. 68-11522				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) George Donald Riley		2. DATE AND HOUR OF DEATH November 14, 1968 2:45 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in Pines, Belvedere		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 12-02 C. CITY OR TOWN Baltimore, 21218 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3401 Greenway		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1885 9. AGE (In years last birthday) 83 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sports Writer		10B. KIND OF BUSINESS OR INDUSTRY News & Radio		11. BIRTHPLACE (State or foreign country) Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Dr. Elihu S. Riley, Jr.		
14. MOTHER'S MAIDEN NAME Rebecca Williams Tucker		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		
16. SOCIAL SECURITY NO. 212-10-2975		17. INFORMANT Mrs. Virginia M. Riley ADDRESS (Same)		
18. 412.4-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary edema 1 hour (B) Arteriosclerotic cardiovascular disease 10 years (C) Chronic obstructive pulmonary disease 15 years Peripheral neuritis with atrophy of leg muscles 5 years		
19A. DATE OF OPERATION 5-27-2 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from April 26, 1949 to November 14, 1968 , that (I) (we) last saw the deceased alive on November 6, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.				
23A. SIGNATURE John Tilden Howard, M.D.		23B. DATE SIGNED Nov. 15, 1968		
23C. PHYSICIAN'S NAME (Type) Dr. John Tilden Howard		23D. ADDRESS 12 E. Eager St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/18/68		24C. NAME OF CEMETERY or CREMATORY Baltimore National
24D. LOCATION Baltimore		24E. (City, town, or county) Md.		
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Balt 12, Md.



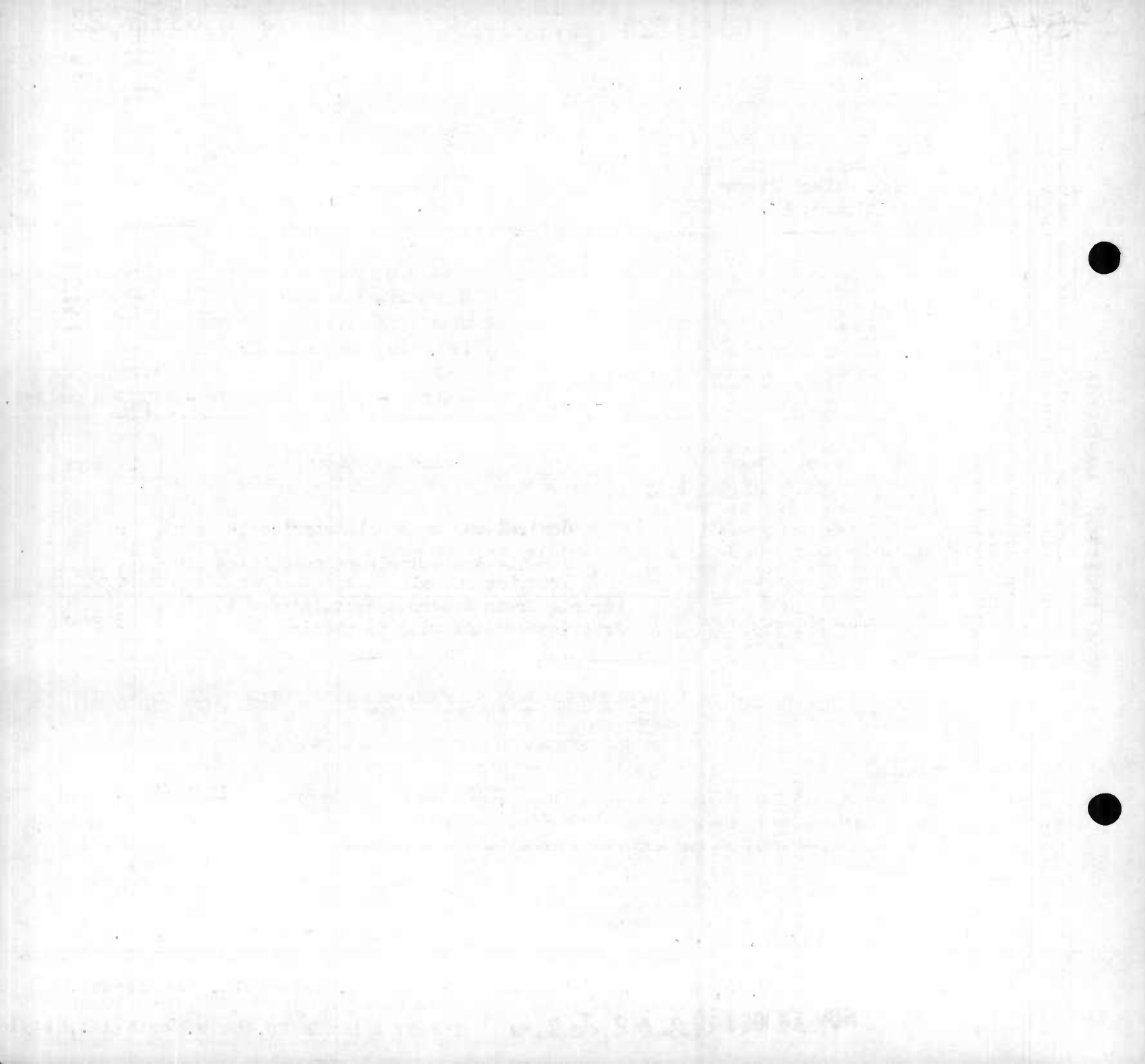
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11523 CERTIFICATE OF DEATH

REG. NO. 68-11523

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Reverend Thomas A. Campbell		2. DATE AND HOUR OF DEATH 11/16/68 7:27 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE New Jersey B. COUNTY V-27			
FULL NAME OF HOSPITAL OR INSTITUTION The Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Md. 21215		C. CITY OR TOWN North Plainfield		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER (St. Joseph's Rectory)		5. SEX Male		6. RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/10/90		9. AGE (In years lost birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York, New York	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Mr. Thomas Campbell		14. MOTHER'S MAIDEN NAME Mrs. Mary Campbell Campbell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 150-42-4206		17. INFORMANT Records - Seton Institute - 6400 Wabash Ave.	
18. 437.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: General and cerebral Arteriosclerosis		?	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Brain Syndrome associated with Arteriosclerosis		3 years	
		(C) Arteriosclerosis		3 years	
19A. DATE OF OPERATION 334X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Chronic Brain Syndrome associated with Arteriosclerosis with psychosis		19C. AUTOPSY? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> No	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from 2/20/68 19 to 11/16/68 19, that ON (we) last saw the deceased alive on 11/16/68 19 and that in (301) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) NOT view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 11/17/68			
23C. PHYSICIAN'S NAME (Type) Raphael Nigrin, M.D.		23D. ADDRESS 6400 Wabash Avenue, Baltimore, Md. 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 20, 68		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) S. Plainfield, New Jersey.		25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968			
25B. NAME OF REGISTRAR Robert E. Edwards		25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN CO. 108 W. North Av., Cityl			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11524 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11524

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Gottfred Byer Sr.		2. DATE AND HOUR OF DEATH 11/15/1968 10:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00				A. STATE Md.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2222 Louise Ave.				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2222 Louise Ave.	
5. SEX M.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/20/1908	9. AGE (In years last birthday) 60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Henry Byer				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				14. MOTHER'S MAIDEN NAME - Wickman	
16. SOCIAL SECURITY NO. 213-03-2501				17. INFORMANT Margaret Byer same	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cormary occlusion, acute				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Arteriosclerosis C.V.D. necr.				5 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II Peripheral Numbness in legs Vitamin deficiency				5 mns	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPTIC (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7 May 1968 to 5 Nov 1968 , that (I) (we) last saw the deceased alive on 5 Nov 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Howard Goodman				23B. DATE SIGNED 15 Nov 68	
23C. PHYSICIAN'S NAME (Type) Howard Goodman M.D.				23D. ADDRESS 8604 Harford Rd Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/19/68		24C. NAME of CEMETERY or CREMATORY Glen Haven	
24D. LOCATION Glen Burnie, Md.		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.	
25D. ADDRESS					

FUNERAL DIRECTOR: IMPORTANT

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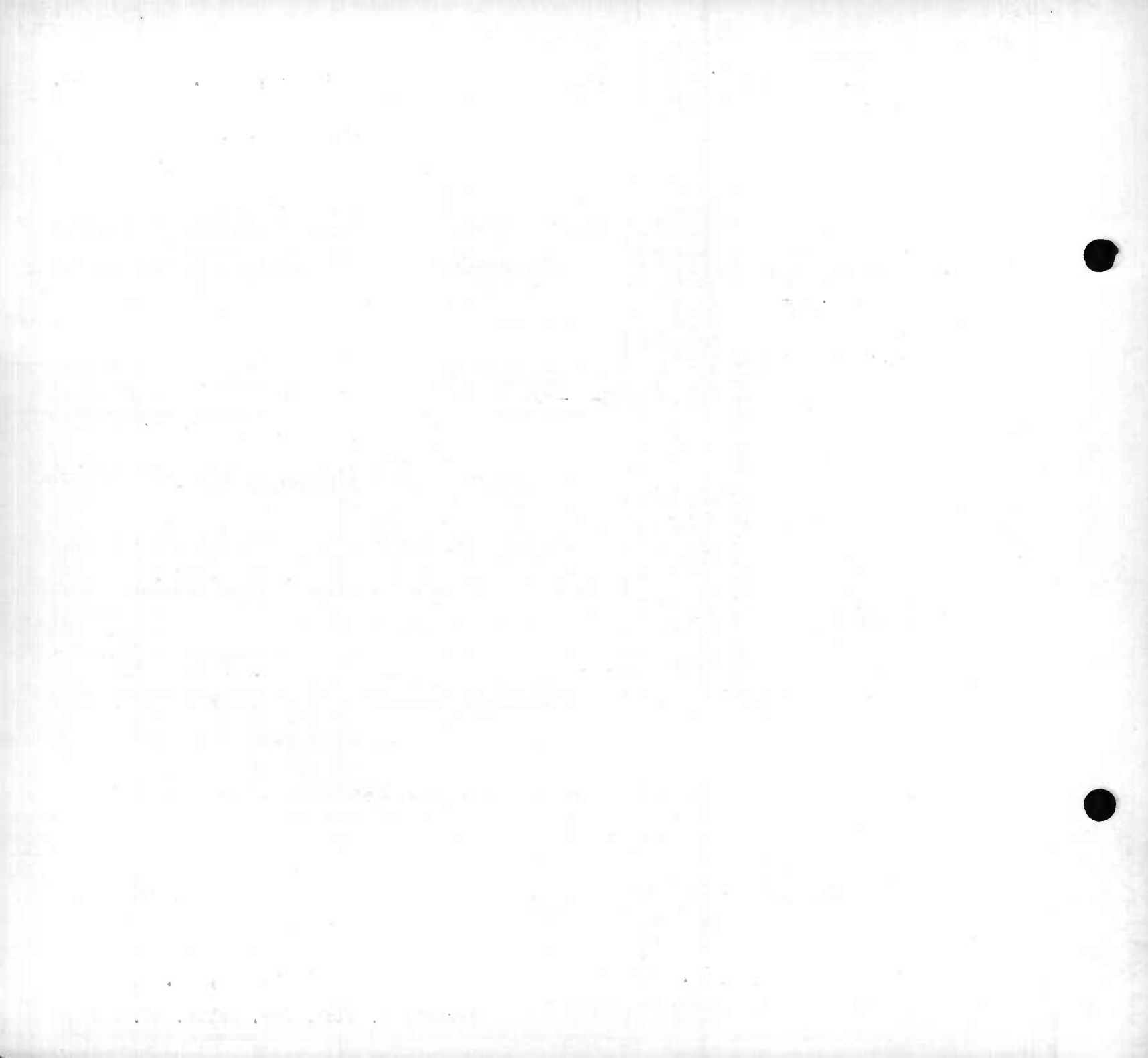
68-11525 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11525

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CATHERINE H. LIGHTNER		2. DATE AND HOUR OF DEATH November 17, 1968. 6P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-34		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP 44		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1/9/96		9. AGE (In years last birthday) 72		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNA	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME FRANK HERBERT		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-4608		17. INFORMANT ADDRESS ANNA M. WOOD SAME	
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH > Massive intracerebral (A) IMMEDIATE CAUSE INTRACEREBRAL DUE TO, OR AS A CONSEQUENCE OF: HEMORRHAGE > Aspiration into nasopharyngeal tube (B) DUE TO, OR AS A CONSEQUENCE OF: Massive pulmonary emphysema (C) beatrual 78. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days		19. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 11/14/68 19 to 11/17/68 19 that (I) (we) last saw the deceased alive on 11/17/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Charles S. Bevan		23B. DATE SIGNED 11/17/68		23C. PHYSICIAN'S NAME (Type) Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/21/68		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE OF BURIAL NOV 18 1968		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. Balto. Md. 21214	



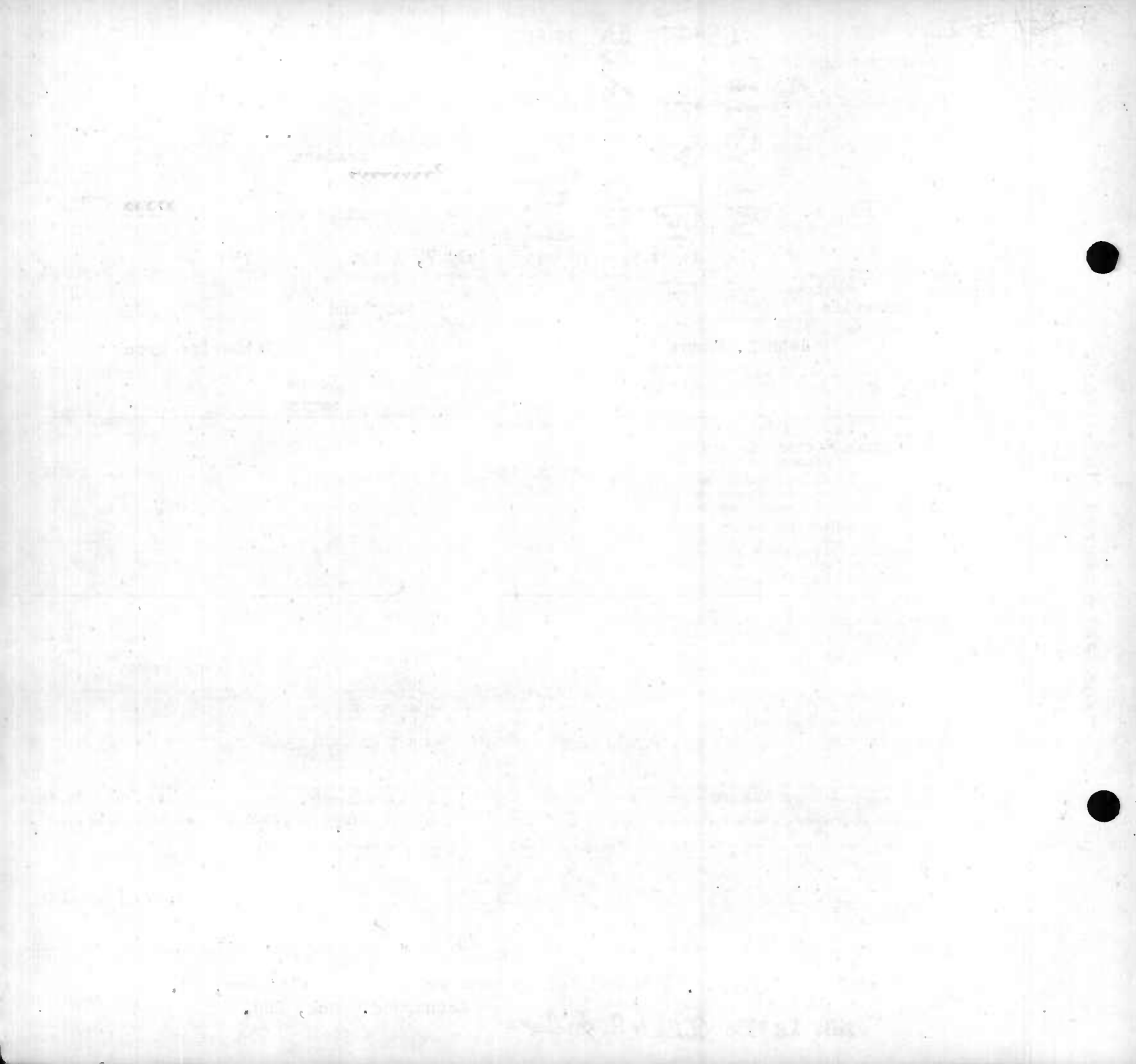
FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT
68-11526 CERTIFICATE OF DEATH

REG. NO. 68-11526

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Florence M.. Fletcher		2. DATE AND HOUR OF DEATH Nov. 17, 1968 <u>12³⁰</u> <u>P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY A.A. Cal. <u>52-00</u>		C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 90 1105 E. Fayette Street		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 8536 Jenkins Road <u>21222</u> 21122	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH July 7, 1893.	9. AGE (In years last birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John L. Kampe		14. MOTHER'S MAIDEN NAME Katherine Bruck		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 18 3978A		17. INFORMANT Kampe ADDRESS Mr.. Andrew Kamp 8536 Jenkins road	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ASCVD (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sev. Years ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sev. Years			
18. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (was in hospital) attended the deceased from Oct. 15, 1968 to Nov. 17, 1968 , that (I) (was) last saw the deceased alive on Nov. 17, 1968 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook M.D.				23B. DATE SIGNED Nov. 17, 1968	
23C. PHYSICIAN'S NAME (Type) E. Ellsworth Cook		23D. ADDRESS M.D. DEGREE 2430 2431 Maryland Ave			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 11/20/68		24C. NAME of CEMETERY or CREMATORY National Loudon Cemetery	
24D. LOCATION Baltimore, Md.		24E. NAME of FUNERAL HOME Edmund J. Bruck, Inc.			
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Fiedler		25C. ADDRESS 2 J. Luck Inc - FA Bawcia	



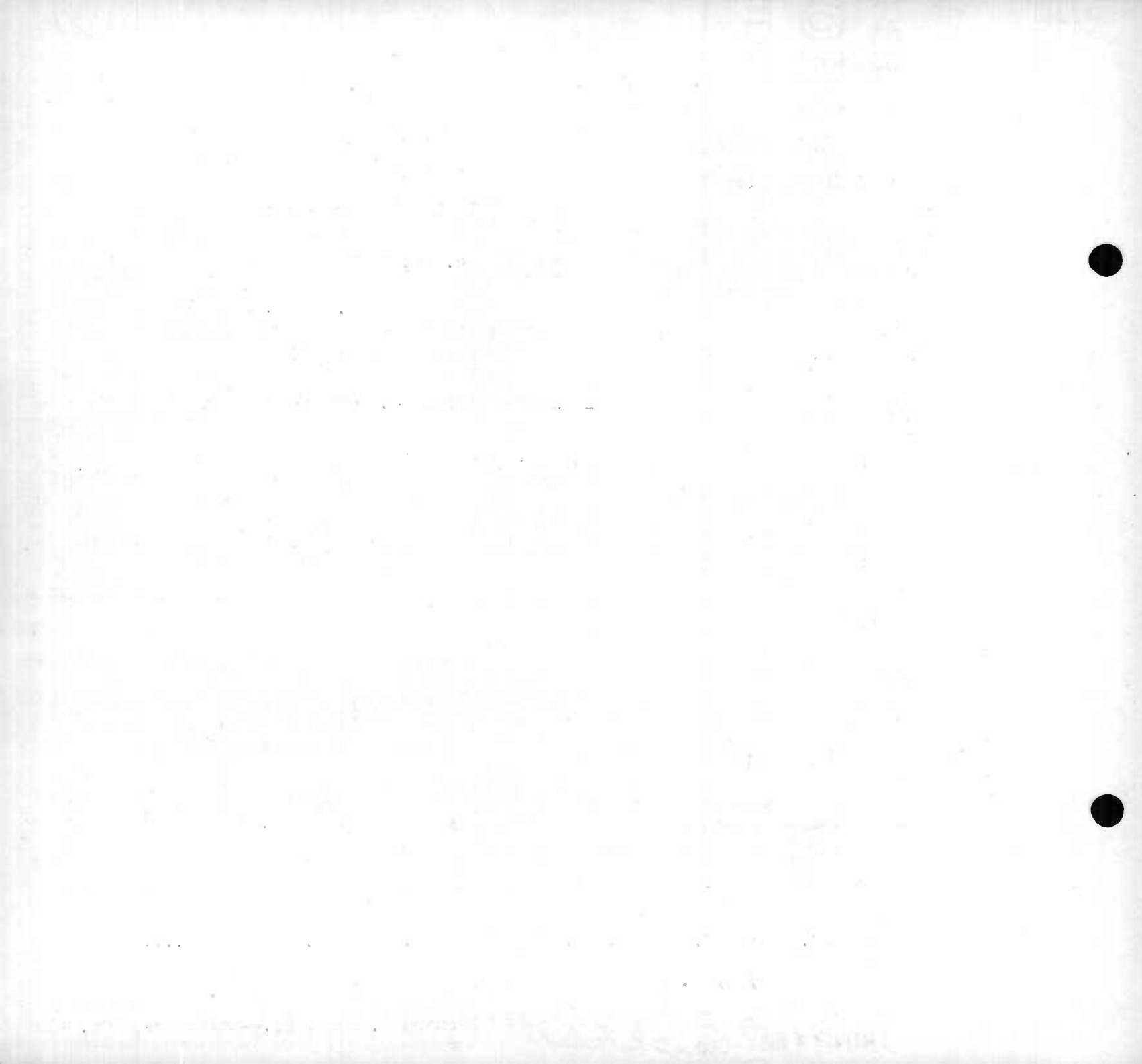
FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT 68-11527 CERTIFICATE OF DEATH

REG. NO. 68-11527

BIRTH NO.		1. NAME OF DECEASED (Type or Print) BESSIE O. BURKHOLDER		2. DATE AND HOUR OF DEATH Nov. 15, 1968 9:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2707		
FULL NAME OF HOSPITAL OR INSTITUTION 00 2712 Kildaire Drive			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2712 Kildaire Drive		
5. SEX female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1897	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William H. Orem			14. MOTHER'S MAIDEN NAME Anna Vonhagel		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-24-4091A	17. INFORMANT ADDRESS Forrest O. Burkholder 2712 Kildaire Drive		
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)..... APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.					
MEDICAL CERTIFICATION					
19. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-2 19 63 to 11-15 19 68 , that (I) (we) last saw the deceased alive on 11-10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Alfred G. Ossman, Jr. DEGREE				23B. DATE SIGNED 11-18-68	
23C. PHYSICIAN'S NAME (Type) Dr. Alfred G. Ossman, Jr. DEGREE				23D. ADDRESS 1101 St. Paul St., Balto, Md....21202	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 11/19/68		24C. NAME OF CEMETERY or CREMATORY PARKWOOD Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR NOV 18 1968 Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc.--Baltimore, Md. -14	



68-11528

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LORRAINE H. MILLER

2. DATE AND HOUR OF DEATH

November 15, 1968

11¹⁵

P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

BALTIMORE

YES ☒NO ☐

E. STREET AND NUMBER

4806 E. HOFFMAN ST.

#21205

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

4-25-22

9. AGE (In years
last birthday)

46

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George Moran

14. MOTHER'S MAIDEN NAME

Lena English

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

234-30-0210

17. INFORMANT

ADDRESS

21224

RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD

18. 148.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

METASTATIC HYPOPHARYN-
GEAL CARCINOMA

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 year?

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from
that (I) (we) last saw the deceased alive on 11/15 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Torres
JOSE TORRES MD

DEGREE

Attending ☐Med. Director ☐Staff ☒
Phys.

23B. DATE SIGNED

11-15-68

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

BCH-4940 EASTERN AVENUE, BALTIMORE, MD 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/20/68

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 18 1968

25B. NAME OF REGISTRAR

R. E. E. Jones

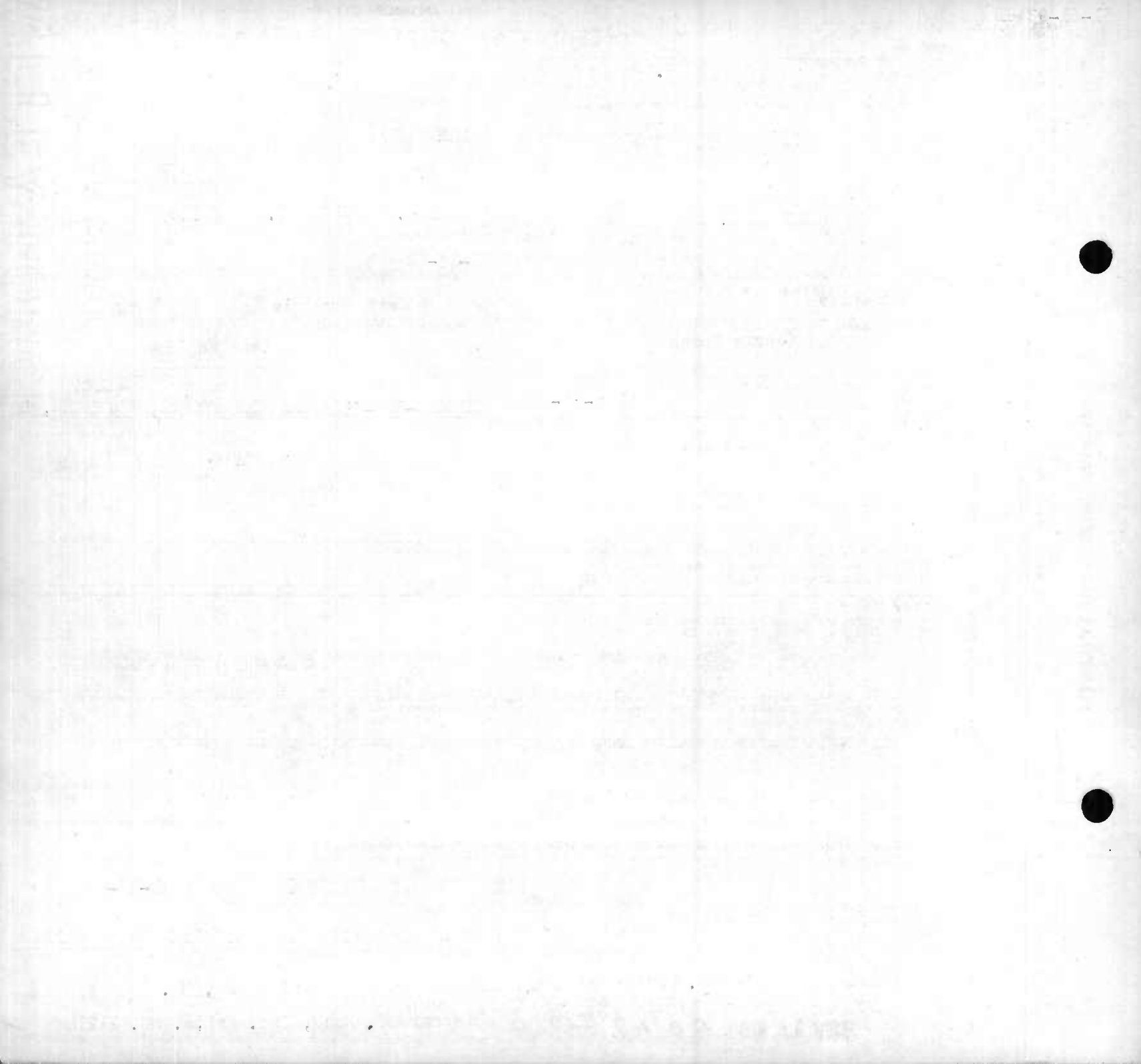
25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



Released on approval

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11529	
<div style="display: flex; justify-content: space-between;"> Released on approval 68-11529 CERTIFICATE OF DEATH </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) KNIGHTON, HOWARD P.			2. DATE AND HOUR OF DEATH NOV. 16, 1968 2:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSP.			A. STATE MD - BALTO.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33rd & Calvert Sts.			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M			6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY Balto. G. & E. Co.		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME JOHN THOMAS KNIGHTON			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 215-099163		17. INFORMANT Mr. WILLIAM KNIGHTON - SAME
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH EMPHYSEMA			CAUSE OF DEATH PULMONARY THROMBOEMBOLUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			IMMEDIATE CAUSE Cardiac Arrest		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF: Fracture, RIGHT HIP.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E904.0 II					
19A. DATE OF OPERATION NOV. 7, 1968			19B. CONDITION FOR WHICH OPERATION WAS FRACTURE, RE. HIP.		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 1030 AM			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1522 KINGWAY ROAD, BALTO.
21D. TIME OF INJURY (APPROX.) NOV. 7, 1968			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell at home.
22. I certify that (I) (this hospital) attended the deceased from NOV. 7 19 68 to NOV 16 19 68 , that (I) (we) last saw the deceased alive on NOV. 16 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Antonio J. Ruck MD.			23B. DATE SIGNED NOV. 16, 1968.		
23C. PHYSICIAN'S NAME (Type) Antonio J. Ruck MD.			23D. ADDRESS THE UNION MEMORIAL HOSP. 33RD AND CALVERT STS.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/20/68	24C. NAME OF CEMETERY or CREMATORY Baltimore Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Sweeney		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11530 **CERTIFICATE OF DEATH**

REG. NO.

68-11530

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET DURHAM

2. DATE AND HOUR OF DEATH

November 14, 1968.

6:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2007 Belair Road

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Jan. 20, 1907.

9. AGE (In years lost birthday)

61

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cashier

10B. KIND OF BUSINESS OR INDUSTRY

Dept. Store

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Jacob Dieter

14. MOTHER'S MAIDEN NAME

Margaret Manner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.
212-09-8463

17. INFORMANT

Mr. Albert Krider

ADDRESS

(Same)

18. **410.9 I**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

acute myocardial infarct

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Heart Disease

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

instant

2 yrs.

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from **April 28** 19**67** to **Nov. 14** 19**68**, that (1) (we) last saw the deceased alive on **Nov. 12** 19**68** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Walter R. Welzant, M.D.

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

Nov. 15, 1968

23C. PHYSICIAN'S NAME (Type)

Walter R. Welzant, M. D.

23D. ADDRESS

422 Medical Arts Bldg. Balto. Md 21201

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/18/68.

24C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D

NOV 18 1968

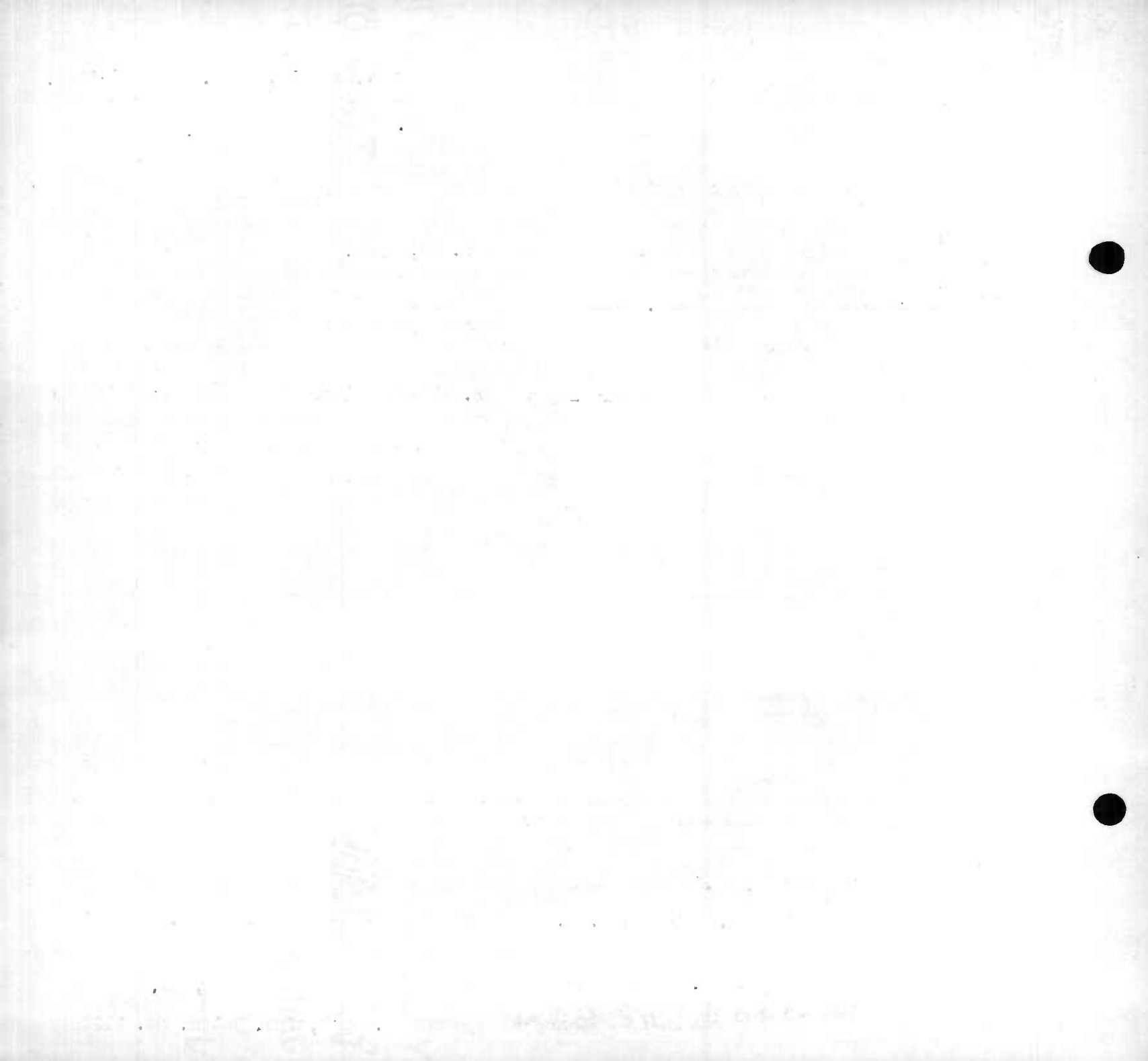
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11531

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN H. BROWN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> November 13, 1968		Month Day Year Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD November 13, 1968		Month Day Year Hour 5:43 P.M.
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH March 21, 1943		10. AGE (In years lost birth day) 25		11. BIRTHPLACE (State or foreign country) Woodward S. C.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Eugene Brown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemp. Foster
15. MOTHER'S MAIDEN NAME Eva Foster		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.
18. INFORMANT Eva Brown		ADDRESS		
19. CAUSE OF DEATH #28X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Focal myocarditis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. #22 2x II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Lacerations, contusions and abrasion of head		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Focal myocarditis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Tavern		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1548 N. Gay Street
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 11-13-68 5:15 P. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Involved in altercation
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 14, 1968				
24A. BURIAL CREMATION, REMOVAL (Specify) Burned		24B. DATE 11/18/68		24C. NAME OF CEMETERY or CREMATORY mt Auburn Cem
24D. LOCATION (City, town, or county) (State) a. a. County Md		25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Jenkins
25C. FUNERAL DIRECTOR James T. Elickson		ADDRESS 1129 N. Caroline St		

Superior
Cable
Cable
Cable

Handwritten
2.0
Handwritten
Handwritten

Handwritten

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11532

BIRTH NO.

1. NAME OF DECEASED (Type or Print) OAKLEY SCHENCK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 11-16-68 12:15 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH May 8, 1912		10. AGE (In years lost birthday) 56	
11. BIRTHPLACE (State or foreign country) Monkton, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY None	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 2552	
18. INFORMANT Abe Schenck		ADDRESS 2552 Druid Park Ave.	
19. CAUSE OF DEATH E890 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carbon monoxide intoxication (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) Home	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 11-15-68 11:53 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1301 Myrtle Ave.		22F. HOW DID INJURY OCCUR? Found in burning building	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 11/18/68	
24C. NAME OF CEMETERY or CREMATORY Kings Mountain N.C.		24D. LOCATION (City, town, or county) (State) 1129 N. Carolina	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Isakson	
25C. FUNERAL DIRECTOR Isakson		ADDRESS 1129 N. Carolina	

General 11/18/68

Franklin D. Roosevelt
Library, Mount Vernon, N.Y.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11533
BIRTH NO. 68-11533		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) MARY Epps		2. DATE AND HOUR OF DEATH 13 Nov 1968 7:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 147 S. Calverton Road.		
5. SEX F	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/20/09	9. AGE (In years last birthday) 59
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNK.		10B. KIND OF BUSINESS OR INDUSTRY UNK	11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Epps		14. MOTHER'S MAIDEN NAME Rebecca BANNER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNK	17. INFORMANT CHART ADDRESS	
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Disseminated Carcinoma of Breast (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Congestive heart failure		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 8 Nov 1968 to 13 Nov 1968 , that (I) (we) last saw the deceased alive on 13 Nov 1968 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Edward D. Layne		23B. DATE SIGNED 13 Nov 1968		23C. PHYSICIAN'S NAME (Type) Edward D. Layne
24A. BURIAL CREMATION, REMOVAL (Specify) Burial Nov 19/68		24B. NAME OF CEMETERY OR CREMATORY Westport Md		24C. LOCATION (City, town, or county) (State) Westport Md
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Elliot Funeral Home ADDRESS 1129 Caroline St. Mount Airy, Ellicott City

Received of Mr. J. H. [illegible] the sum of [illegible]

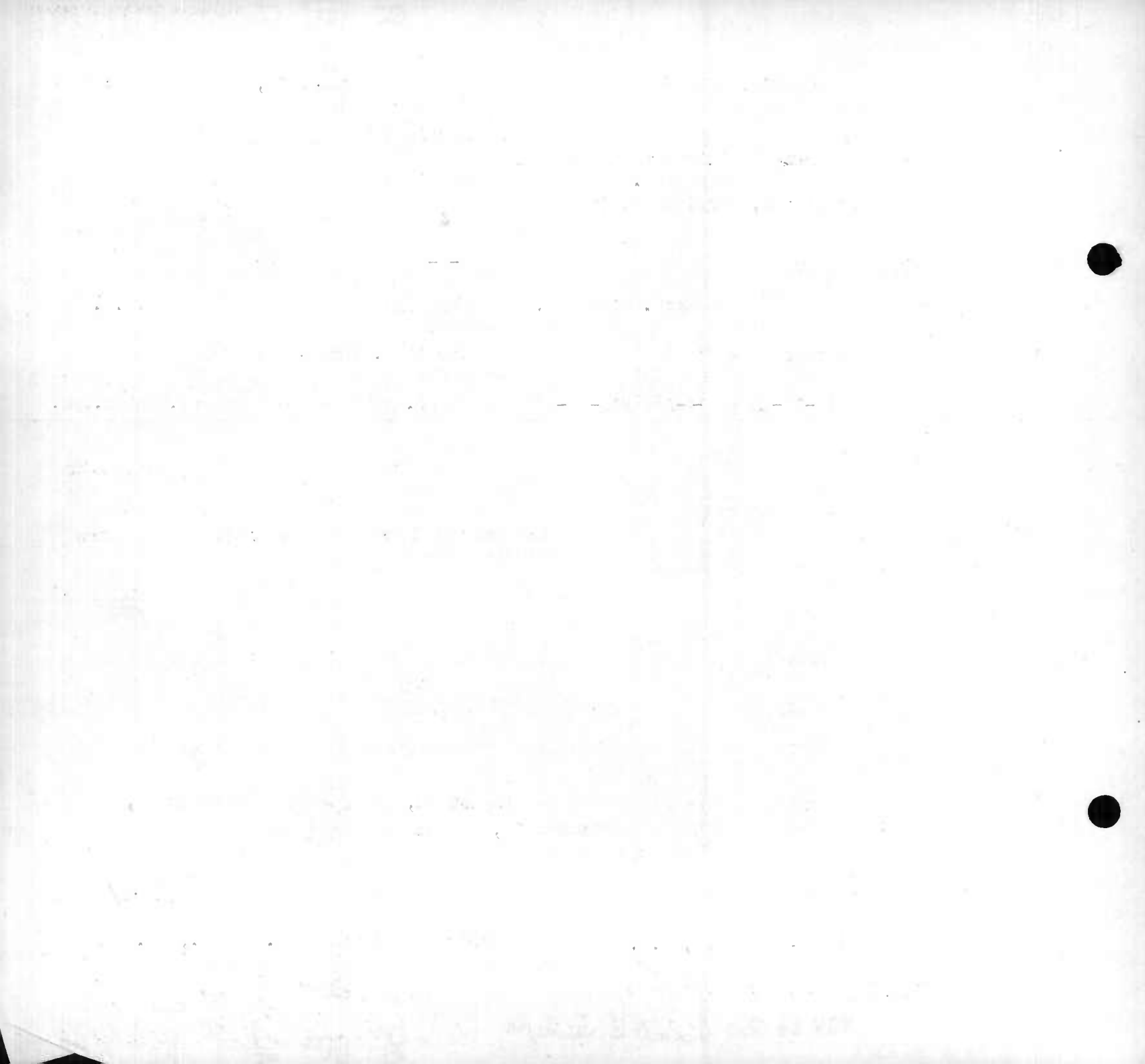
for [illegible] [illegible] [illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11534 CERTIFICATE OF DEATH

REG. NO. 68-11534

BIRTH NO.		1. NAME OF DECEASED (Type or Print) COATES, Walter Sherman		2. DATE AND HOUR OF DEATH November 14, 5:40 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-13			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2665 Oswego Ave		2665			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-22	9. AGE (In years last birthday) 46	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Kenneth Coates			
14. MOTHER'S MAIDEN NAME Carrie U. Thomas		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10-19-42 to 11-46			
16. SOCIAL SECURITY NO. 214-14-4130		17. INFORMANT Records ADDRESS 21218 VA Hosp. 3900 Loch Raven Blvd. Balto., Md.			
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Uremia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus & hypertension		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Uremia (B) Diabetes Mellitus & hypertension DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months 6 years	
19. 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from August 16, 19 68 to November 14, 19 68 , that (X) (we) last saw the deceased alive on November 14, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ruth Ann Przybysz, M.D.</i>		23B. DATE SIGNED 11/14/68		23C. PHYSICIAN'S NAME (Type) RUTH ANN PRZYBYSZ, M.D.	
23D. ADDRESS 3900 Loch Raven Blvd. Balto., Md. 21218		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11-18-68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Arlington S. Phillips</i> ADDRESS 172 M. Mount St.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11535

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ROBERT G. ROGERS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 13, 1968 9:15 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour November 13, 1968 9:15 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 5-4-1920		10. AGE (In years lost birthday) 48	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Magnolia Rodgers		ADDRESS 611 Richmond Ave	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED November 14, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		11-18-68	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Mt. Calvary		A.A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Belington Studio		ADDRESS 1727 N. Mount St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68-11536 CERTIFICATE OF DEATH					Registered No. 68-11536				
BIRTH NO. 68-11536					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) West John					2. DATE AND HOUR OF DEATH 11/14/68 1:20 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 8 OF D. STREET ADDRESS (If rural, give location) 2311 E. OLIVER ST.				
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-10-31	9. AGE (In years last birthday) 37	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chuck			10B. KIND OF BUSINESS OR INDUSTRY Bechtel Steel Co.		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME JAMES WEST			14. MOTHER'S MAIDEN NAME HASSIE MYERS						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 214-26-0183		17. INFORMANT Catherine West		ADDRESS Same		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) BRAIN STEM ANOXIA DUE TO (B) MYOCARDIAL INFARCTION DUE TO (C) CORONARY ARTERY DISEASE				INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from Nov 1 1968 to Nov 14 1968 , that (1) (we) last saw the deceased alive on Nov 14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Matthew Pollack					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Nov 14 1968		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-19-68		24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Ullington Phillip		ADDRESS 1727 N. Mount			

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WATERGATE - JAMES EARL RAY

520-3216 13637200 7300493500

① 107 108

Wissenschaften

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11537

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WALTER A. CARTER

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 7, 1968

1:20 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1504 Brentwood Avenue

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Jan 14-21

10. AGE (In years
lost birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1504 Brentwood Avenue

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thad. Carter

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cook

14B. KIND OF BUSINESS OR INDUSTRY

Hotel

15. MOTHER'S MAIDEN NAME

Jennie Jefferson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

W. A. Carter 418 E Oliver St

ADDRESS

19. 412.4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.422.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 7, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-11-68

24C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem Balto

24D. LOCATION (City, town, or county)

Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 18 1968

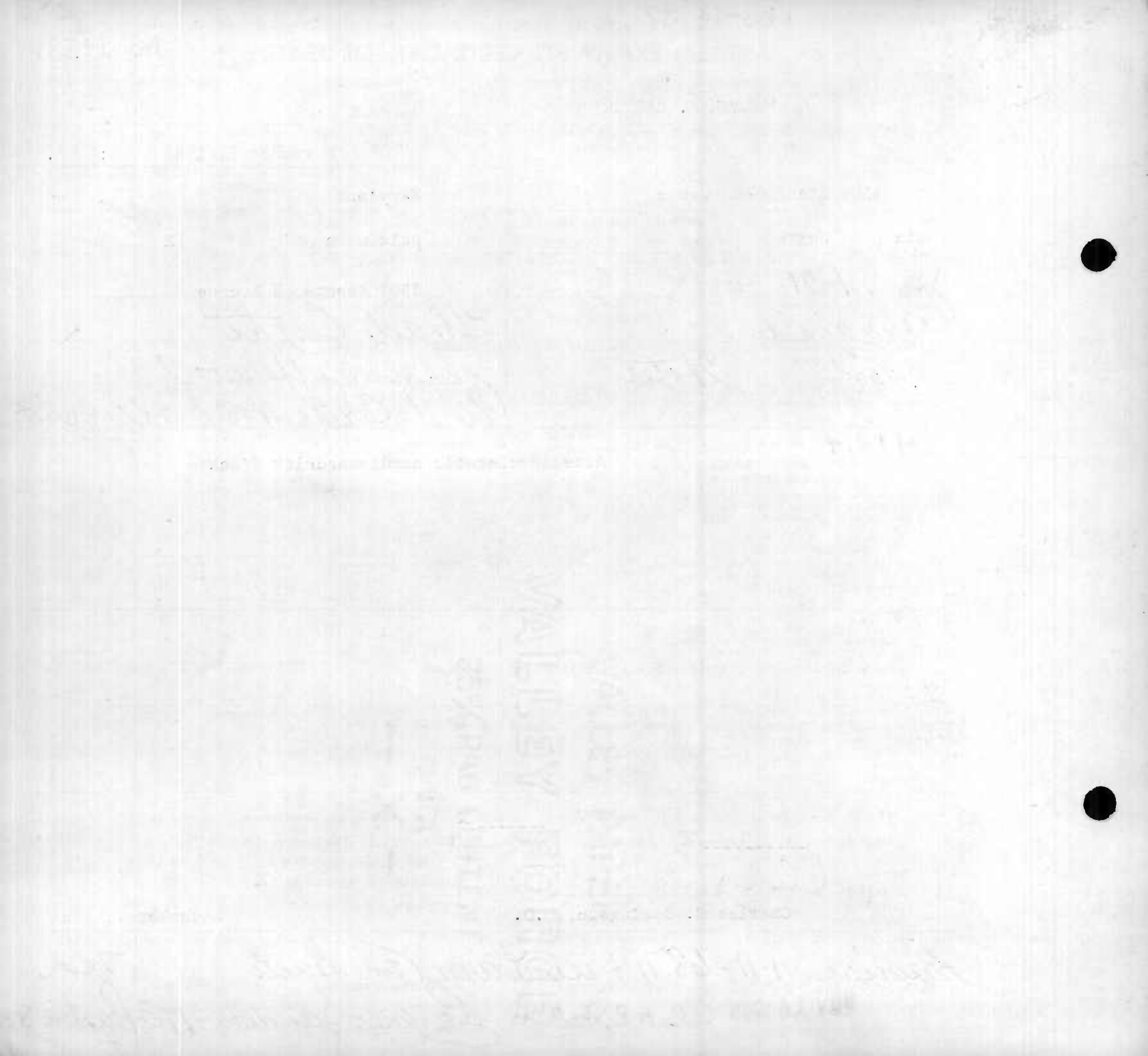
25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Rayner Sanders 217 E. Preston St

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11538 CERTIFICATE OF DEATH

REG. NO. 68-11538

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Rosa Pulliam		2. DATE AND HOUR OF DEATH 11/12/68 5:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 33 900 E. 23rd St 300 E 23 1/2 St					
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-92	9. AGE (In years lost by day) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME James William		14. MOTHER'S MAIDEN NAME Betty Wallace	
15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-56-7055		17. INFORMANT Mary Patterson	
18. 436.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerotic Disease DUE TO, OR AS A CONSEQUENCE OF:		10+ years	
		(C) Hypertension DUE TO, OR AS A CONSEQUENCE OF:		10+ yrs	
19. DATE OF OPERATION 10-3-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ECG MASS		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 9/1/68 to 11/12/68 , that (I) (we) last saw the deceased alive on 11/11/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Jeffrey D. Neill		23B. DATE SIGNED 11/12/68			
23C. PHYSICIAN'S NAME (Type) JEFFREY D. NEILL M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-16-68		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Em R. R. Co	
24D. LOCATION (City, town, or county) (State) Md		25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Rayner Sanders		25D. ADDRESS 217 E. Preston			

4-10-4

Red William

Wentworth Avenue

X

Baltimore

Dec 23 27

Johns Hopkins Hospital

Cardiogram for Arthur J. Smith

~~_____~~

10-1-40

Arteriosclerotic disease

10-1-40

Hypertension

Left ventricular hypertrophy and coronary artery disease; see preceding

11-1-40

11-1-40

11-1-40

11-1-40

X

Robert P. Merrill

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. D-420		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11539
1. NAME OF DECEASED (Type or Print) EMMA DOLCH		2. DATE AND HOUR OF DEATH NOV 10, 1968 8:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1-01		
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 8-28-00		9. AGE (In years last birthday) 68		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Schorr		
14. MOTHER'S MAIDEN NAME Elizabeth		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 216-07-0894A		17. INFORMANT RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224		
18. 15-7-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARCINOMA PANCREAS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MO.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. 15-7-X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 10-17-68		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED JAUNDICE		20A. AUTOPSY? (Yes or No) YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11-5 19 68 to 11-10 19 68 , that (I) (we) lost saw the deceased alive on 11-10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE W E Powers Jr		23B. DATE SIGNED 11-10-1968		23C. PHYSICIAN'S NAME (Type) W E POWERS M.D.
23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE		23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-14-68		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery Baltimore, Md.
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		
25B. NAME OF REGISTRAR R. E. E. E. E.		25C. FUNERAL DIRECTOR Nicholas J. Matthews 3021 Eastern Ave., Baltimore, Md.		

Elisabeth

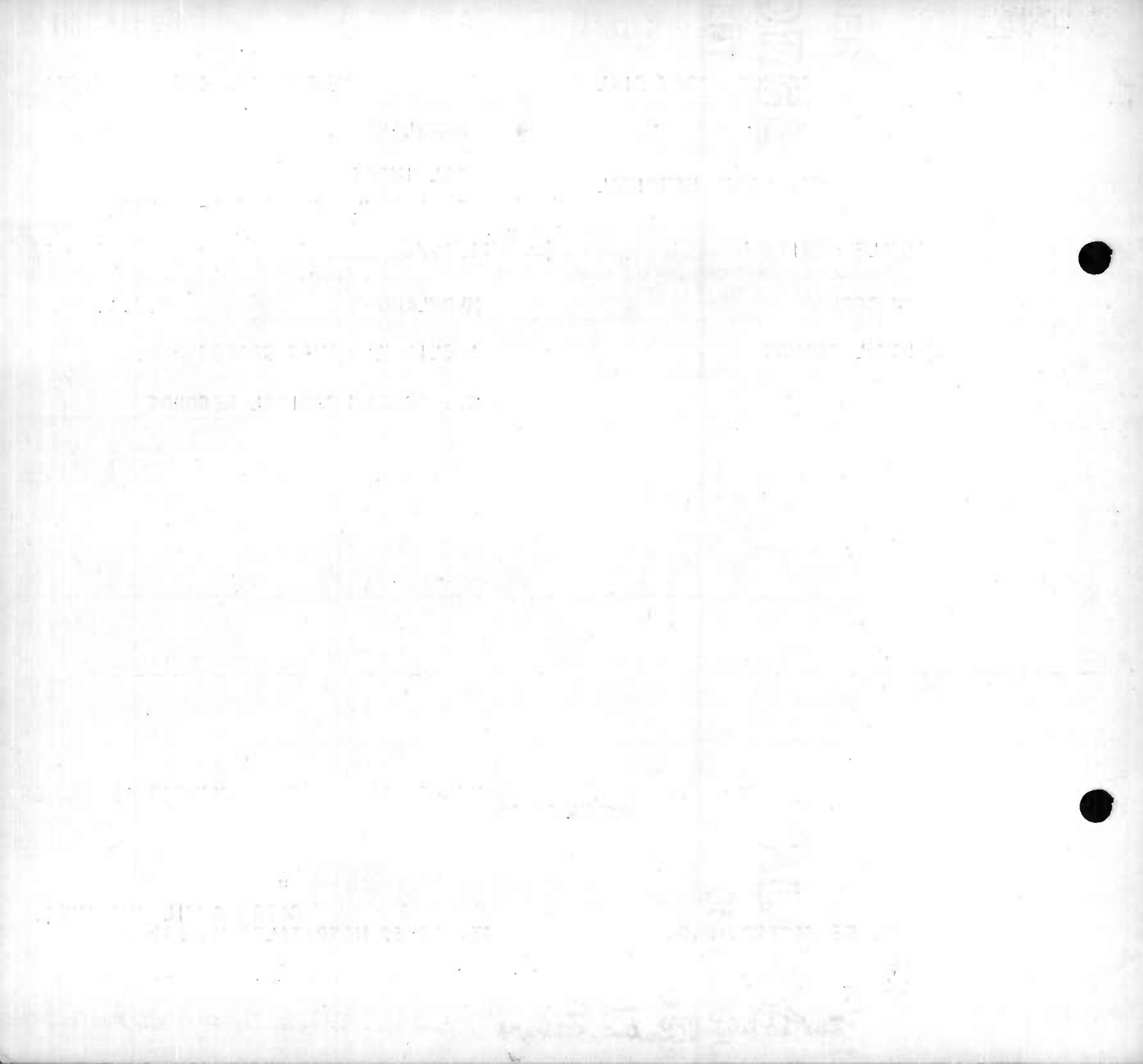
William Scheyer

Bureau of Mt. Carmel Cemetery Baltimore, Md.
Nicholas T. Neumann
201 Eastern Ave. Baltimore

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11540	
BIRTH NO. 68-22641		68-11540		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SPANOS, BABY GIRL			2. DATE AND HOUR OF DEATH NOVEMBER 12, 1968 8:55A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 1407 ANGLESEA APT 2-D 21224 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/68	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: 1 23 If Under 24 Hrs. 23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME MICHEL SPANOS		
14. MOTHER'S MAIDEN NAME AMELIA KARNAVAS SPANOS			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ST. AGNES HOSPITAL RECORDS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 777X I CAUSE OF DEATH IMMATUREITY 22 weeks gestation ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 776X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 12 1968 to NOVEMBER 12 1968 , that (I) (we) last saw the deceased alive on NOVEMBER 12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. De Castro</i> DEGREE			23B. DATE SIGNED 11/12/68		23C. PHYSICIAN'S NAME (Type) M. DE CASTRO, M.D. DEGREE
23D. ADDRESS CATON & WILKENS AVES. ST. AGNES HOSP; BALTO, MD 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-14-68	24C. NAME of CEMETERY or CREMATORY Greek Orthodox Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968	25B. NAME OF REGISTRAR Robert E. Farkner	25C. FUNERAL DIRECTOR Nicholas T. Matthews		ADDRESS 3021 Eastern Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

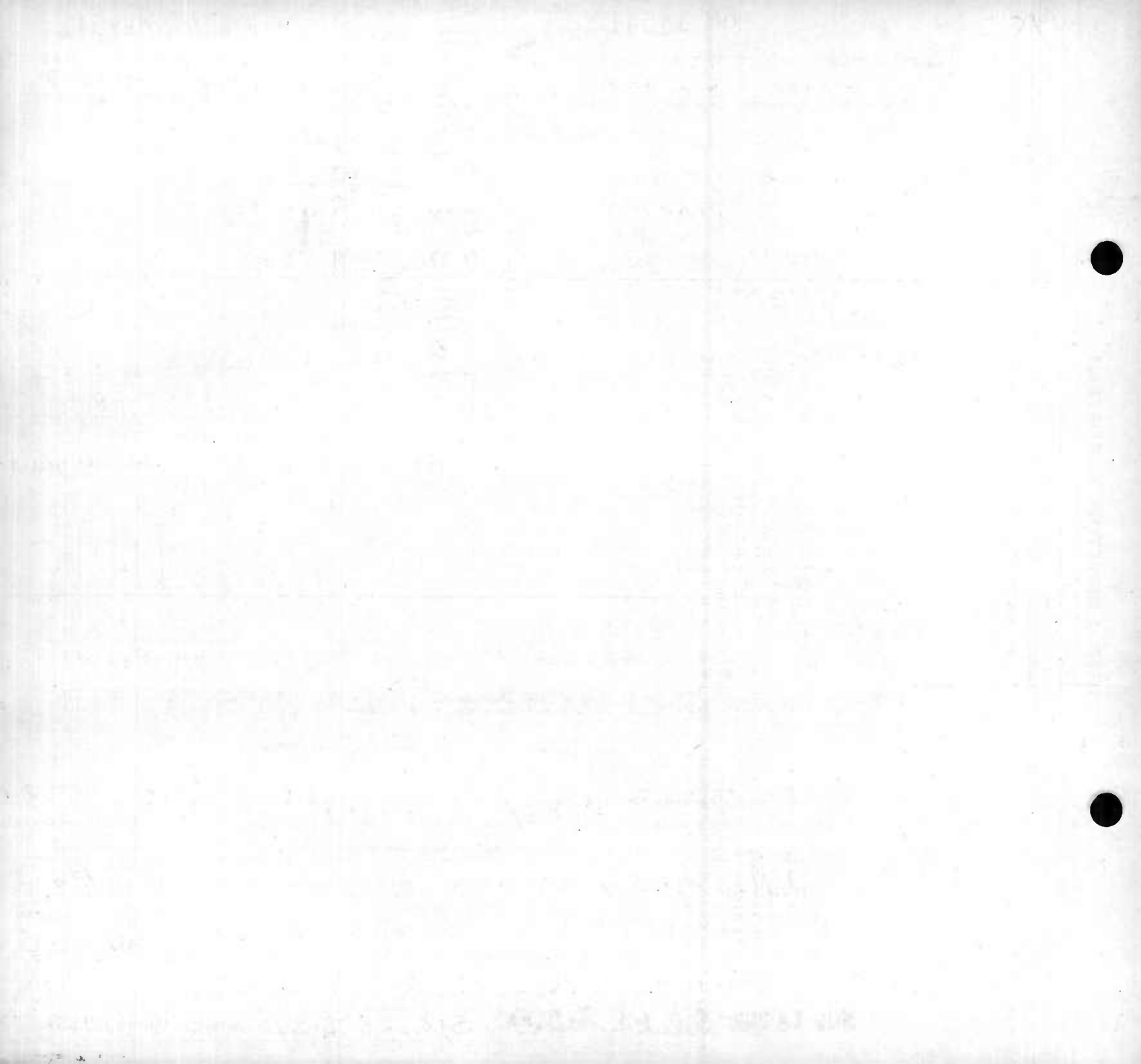
68-11541

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11541

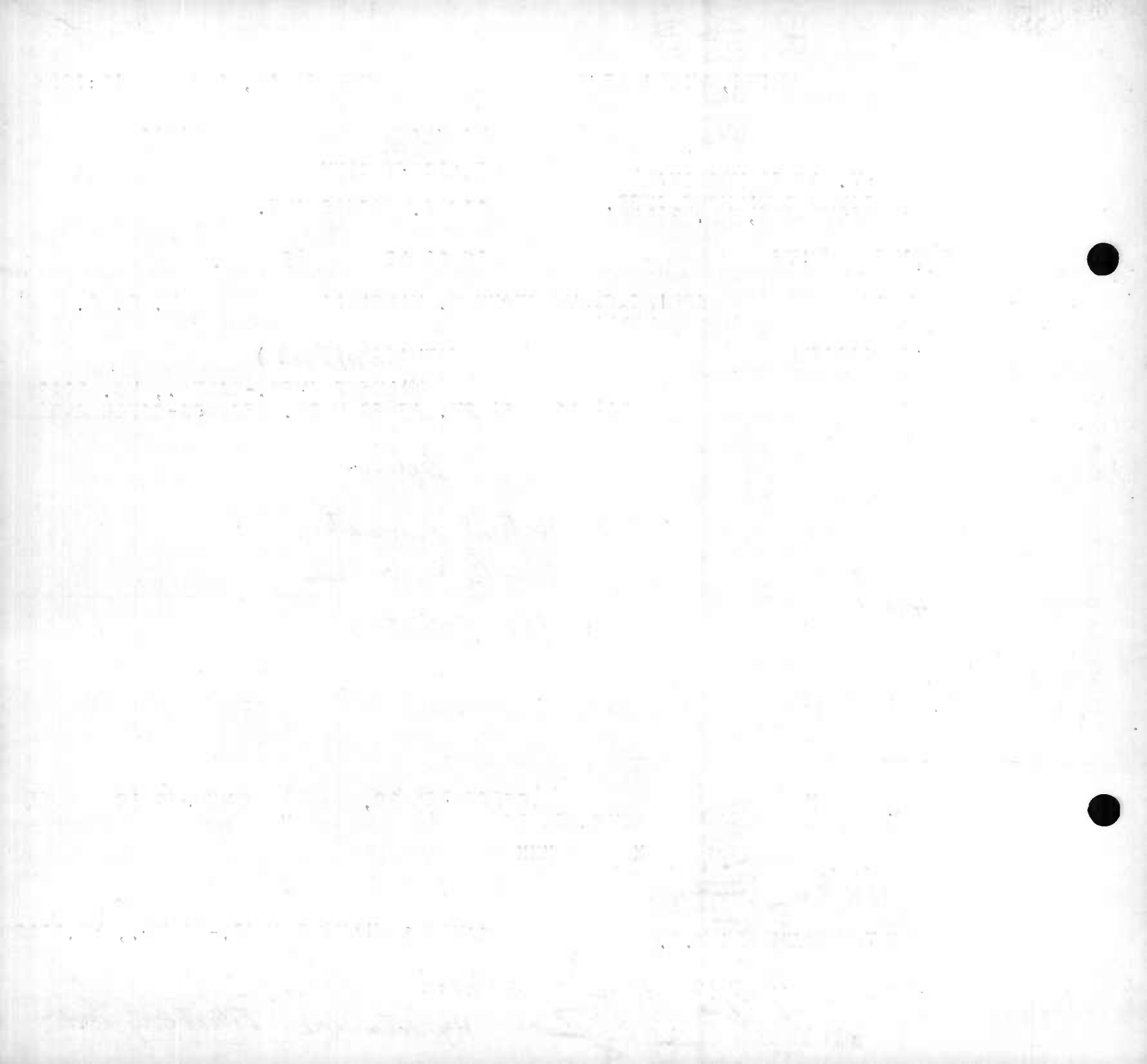
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GERDA SALINGER		2. DATE AND HOUR OF DEATH Nov 14, 1968 4:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 13-04		
FULL NAME OF HOSPITAL OR INSTITUTION 1619 GWYNN FALLS PARKWAY			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1619 GWYNN'S FALLS PKWY		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 DEC 1909	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) CZECH	
13. FATHER'S NAME RABBI DR SAMUEL LINK			14. MOTHER'S MAIDEN NAME PAULA LINK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. —		17. INFORMANT MRS ROSEMARIE GOLBERG
			ADDRESS DR 2259 ROGENE		
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic, hypertensive C.V.D.			CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1964 to 11/12 19 68 , that (I) (we) lost saw the deceased alive on 11/12/ 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Weinberger, M.D.			Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/15/68
23C. PHYSICIAN'S NAME (Type) R. Weinberger, M.D.			23D. ADDRESS 3640 Fords Lane - Baltimore Md. 21215		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/15/68		24C. NAME of CEMETERY or CREMATORY Cherry Avenue Chapel	
				24D. LOCATION (City, town, or county) (State) Randallstown Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, INC	
				ADDRESS 9010 Rustdon	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

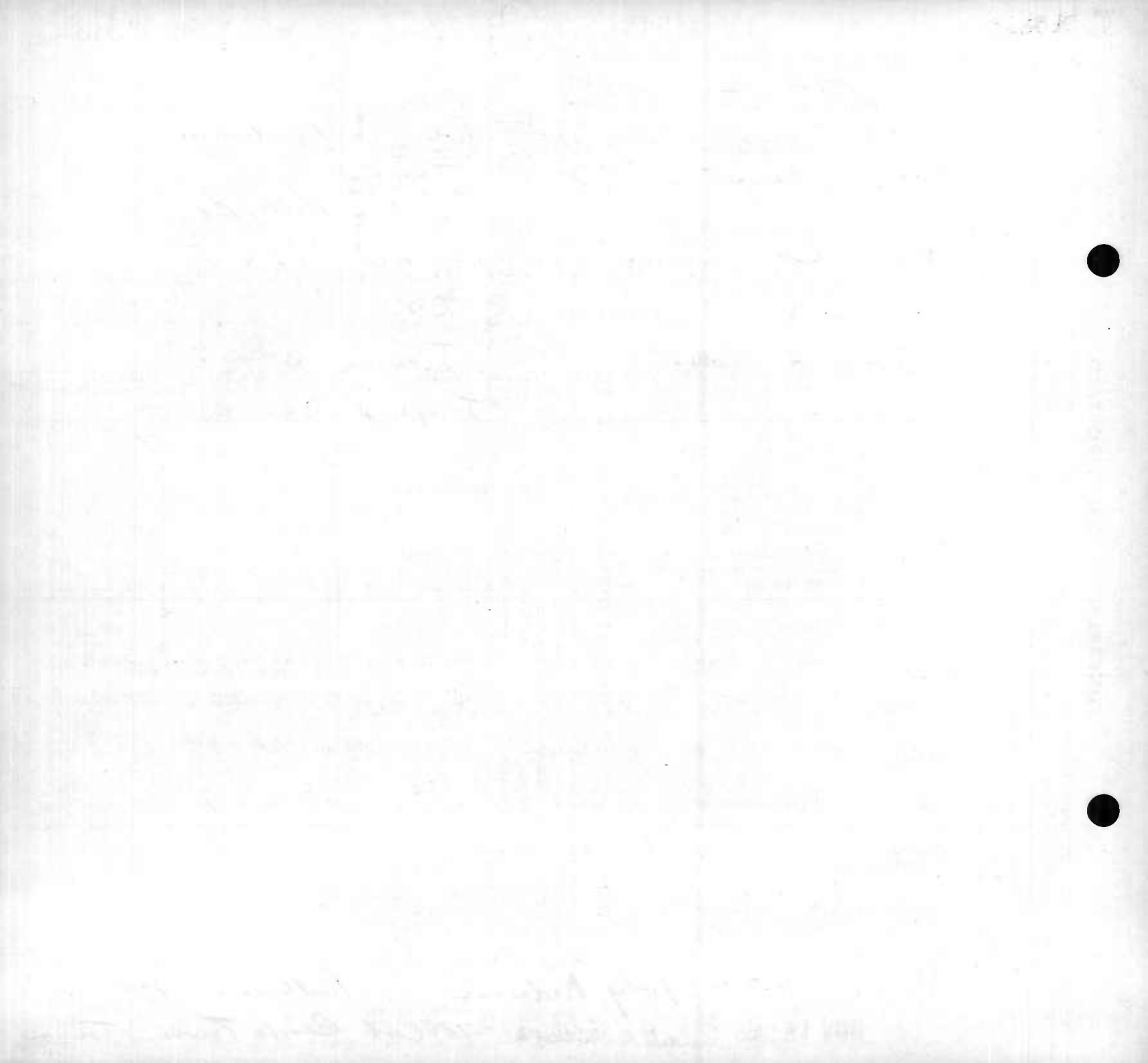
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11542
68-11542 CERTIFICATE OF DEATH				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WHITE, WILMA LENA		
2. DATE AND HOUR OF DEATH NOVEMBER 10, 1968 12:10PM M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Howard Co		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD. 21229		C. CITY OR TOWN 21043 63-00 ELLCOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX FEMALE		6. RACE WHITE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 21 23		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		11. BIRTHPLACE (State or foreign country) SPRING GROVE STATE W. VIRGINIA		
13. FATHER'S NAME FRED CASSELL		14. MOTHER'S MAIDEN NAME BERTHA (PA/ Fred)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 22 6634		
17. INFORMANT WILKENS AVES.-BALTO., MD. 21229		ADDRESS ST. AGNES HOSP. RECORDS-CATON AND		
18. 398X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Septicemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bacterial Endocarditis		
(B) Rheumatic Heart Disease		(C) Status Epilepticus		
19A. DATE OF OPERATION 416X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 20, 19 68 to NOVEMBER 10 19 68 , that (X) (we) last saw the deceased alive on NOVEMBER 10 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Morton Blumberg		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) MORTON BLUMBERG M.D.		23D. ADDRESS CATON & WILKENS AVES.-BALTO., MD. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/13/68		24C. NAME of CEMETERY or CREMATORY Good Shepherd
24D. LOCATION (City, town, or county) (State) Ellicott City Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		
25B. NAME OF REGISTRAR Robert E. Fenderson		25C. FUNERAL DIRECTOR Highlandtown-Stock		
25D. ADDRESS Ellicott City Md.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11543	
BIRTH NO. 68-11543 <i>BRUNNER</i>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Mary Brunner</i>		2. DATE AND HOUR OF DEATH <i>11-16-68 11:45 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mary Hospital</i> <i>37</i>		C. CITY OR TOWN <i>Towson</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <i>Stulenny Valley Rd</i>			
5. SEX <i>F</i>	6. RACE <i>Can</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-11-1884</i>	9. AGE (In years last birthday) <i>84</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John H. Wollen</i>		14. MOTHER'S MAIDEN NAME <i>Johanna Wollen</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Joseph A Brunner</i>	
				ADDRESS <i>706 Cedar Creek Rd Baltimore Md</i>	
18. <i>444.2</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>CARDIORESPIRATORY FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>SUP. MESENTERIC ART. EMBOLOISM</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>ARTERIO SCLEROSIS</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>ONE DAY</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>1</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-29-68</i> 19 to <i>11-16</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-16</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. S. Ranganath M.D.</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>H. S. RANGANATH. M.D.</i>	
23D. ADDRESS		23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-19-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		24E. DATE REC'D BY HEALTH DEPT. <i>NOV 18 1968</i>		24F. NAME OF REGISTRAR <i>Robert E. Jackson</i>	
24G. FUNERAL DIRECTOR <i>Wm. C. Burt</i>		24H. ADDRESS <i>Towson</i>			



FUNERAL DIRECTOR: IMPORTANT

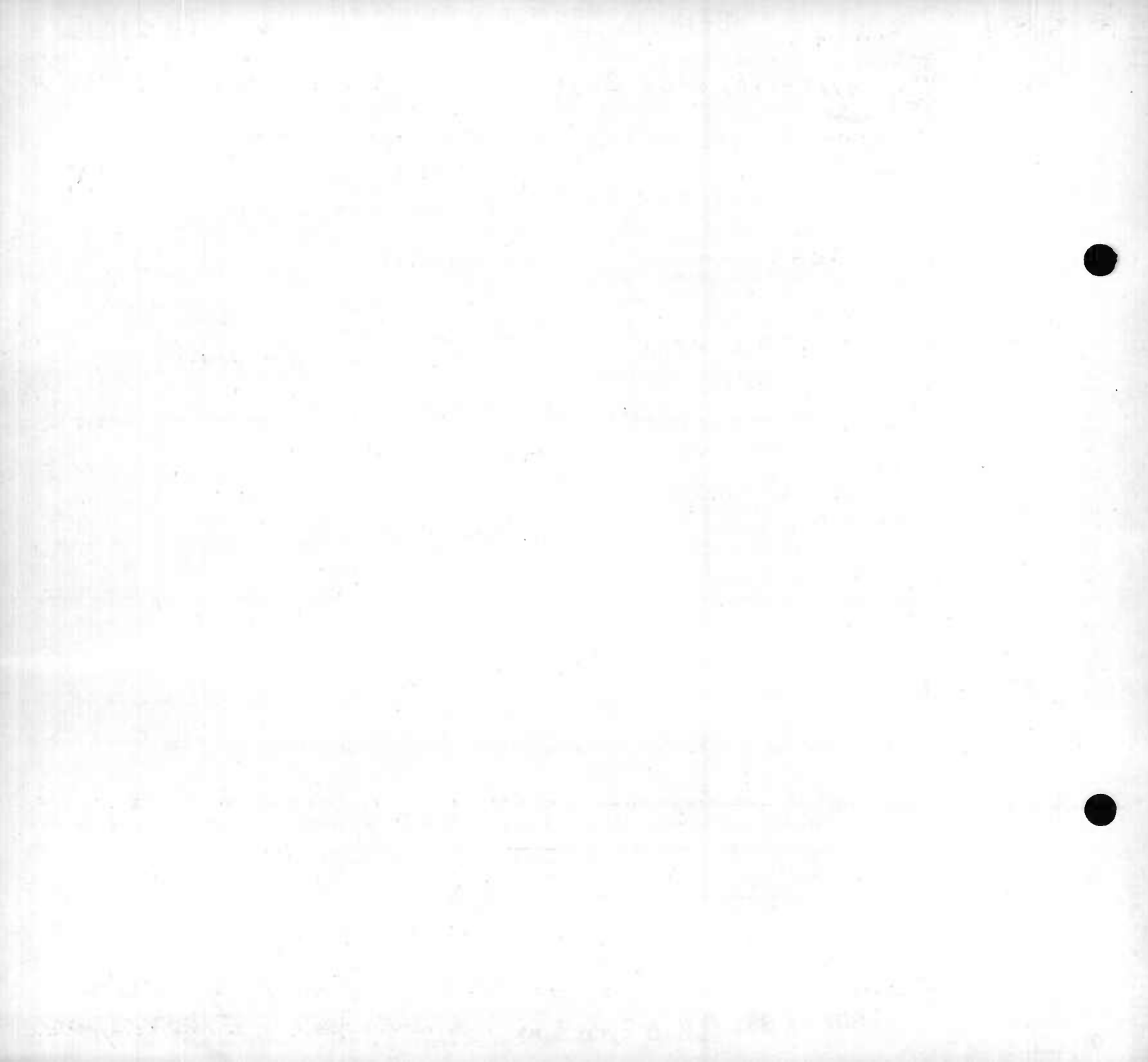
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11544
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SCHATZ, Frederick C.		2. DATE AND HOUR OF DEATH 11-12-68 12:10 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Howard Co 63-00		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		C. CITY OR TOWN JESSUP		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER RT 175 GENDER		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-16-97	9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10B. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frederick C. Schatz		14. MOTHER'S MAIDEN NAME ANNA T. BLANEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-249361	17. INFORMANT ANNA T. McMAHAN ADDRESS SEVERN, Md.	
18. 201X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF: (B) HODGKINS DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): 201X II				
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11-5-68 19 to 11-12 19 68 , that (I) (we) last saw the deceased alive on 11-12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Stephen L. Winter		23B. DATE SIGNED 11-12-68		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) STEPHEN L. WINTER M.D.		23D. ADDRESS UNIV. HOSP.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/15/68	24C. NAME OF CEMETERY or CREMATORY ST Louis	24D. LOCATION (City, town, or county) (State) Clarksville Md.	
25A. DATE REC'D. BY HEALTH DEPT. NOV 18 1968	25B. NAME OF REGISTRAR Robert E. Johnson	25C. FUNERAL DIRECTOR Higginbotham-Slack	ADDRESS Ellicott City, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11545
68-11545		CERTIFICATE OF DEATH		
BIRTH NO. 68-21302		2. DATE AND HOUR OF DEATH NOV. 14, 1968 5:20 A.M.		
1. NAME OF DECEASED (Type or Print) MITCHELL, BABY BOY		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Camell C		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MARYLAND 46		C. CITY OR TOWN WOODBINE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
S. SEX MALE 6. RACE CAU 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 160 DUVAL RD.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		8. DATE OF BIRTH NOV. 11, 1968		9. AGE (In years last birthday) 3
10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FRANCIS W. MITCHELL		14. MOTHER'S MAIDEN NAME Georgia Campbell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOSPITAL RECORD
18. 776.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HYALIN MEMBRANE DISEASE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PREMATURITY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS		
18. 773.5 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from NOV. 11 19 68 to NOV. 14 19 68 , that (I) (we) last saw the deceased alive on NOV 14 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Ronald L. Gutberlet, M.D.				23B. DATE SIGNED Nov. 14, 1968
23C. PHYSICIAN'S NAME (Type) RONALD L. GUTBERLET, M.D.		23D. ADDRESS UNIVERSITY OF MARYLAND HOSP		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-15-68		24C. NAME OF CEMETERY OR CREMATORY Good Shepherd
24D. LOCATION (City, town, or county) (State) ELLICOTT CITY, MD.				
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Hyndalton - BACK
				ADDRESS 12 Ellicott City, Md.



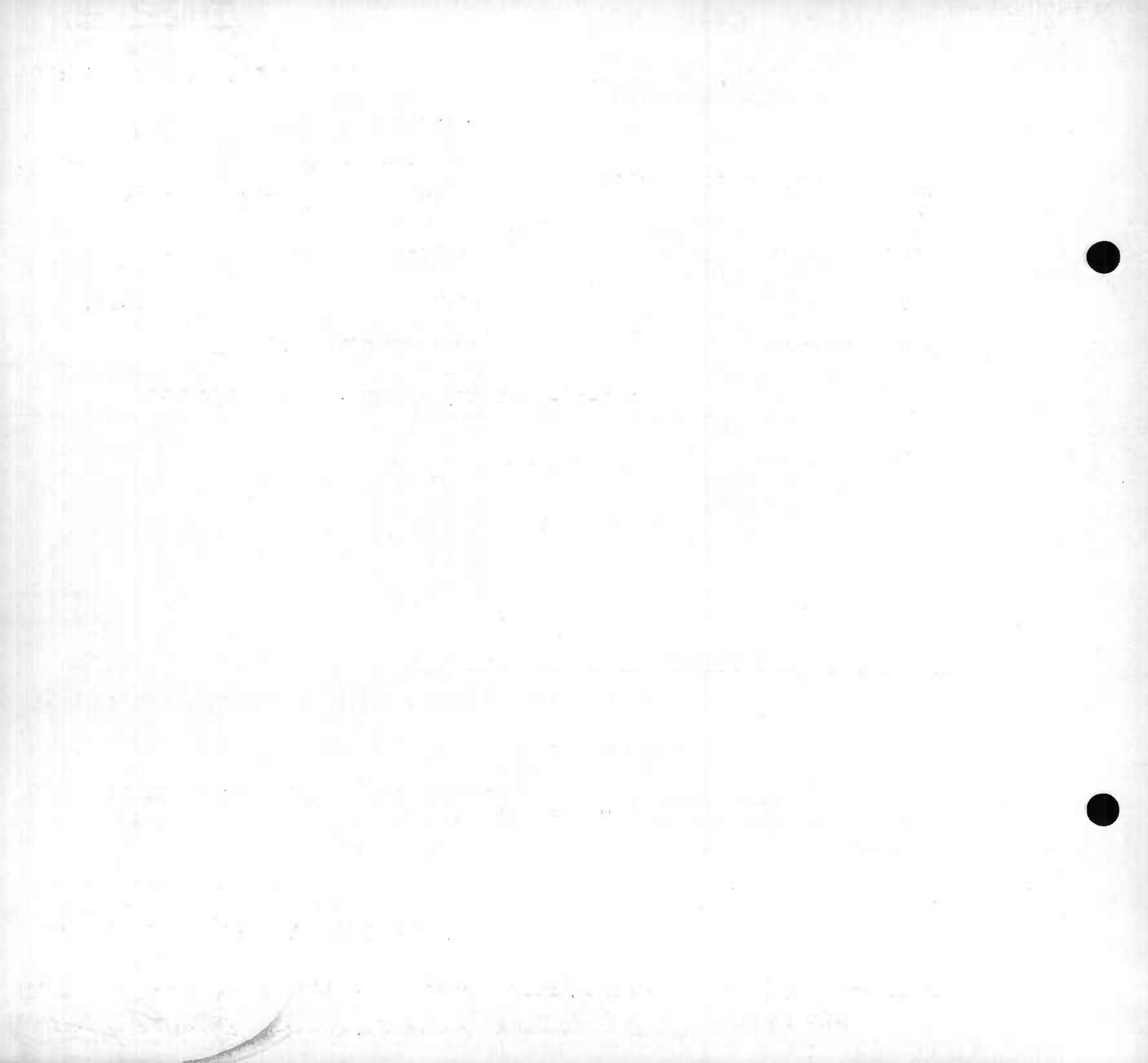
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11546 CERTIFICATE OF DEATH

REG. NO. 68-11546

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MERRYMAN, ROBERT L.		2. DATE AND HOUR OF DEATH NOVEMBER 14, 1968 10:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Howard Co		C. CITY OR TOWN ELLICOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		E. STREET AND NUMBER WATERLOO RD. RT #1 21043			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/37	9. AGE (In years lost birthday) 31	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN MERRYMAN		14. MOTHER'S MAIDEN NAME EMMA STIGLER MERRYMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 213-36-2711		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. 582 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myo inf (B) glomerulonephritis chronic DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 592 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 15 19 68 to NOVEMBER 14 19 68 , that (I) (we) last saw the deceased alive on NOVEMBER 14 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George Anzor		23B. DATE SIGNED 11/14/68			
23C. PHYSICIAN'S NAME (Type) GEORGE ANZOR		23D. ADDRESS AVES BALTO, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 11-18-68	24C. NAME OF CEMETERY or CREMATORY LAKE VIEW PARK		24D. LOCATION (City, town, or county) (State) ELDENSBURG CARROLL MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Higginbotham & Slack ELLICOTT CITY, MD.	



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08-11547 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11547

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARVEY ALLEN BATES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11-15-68 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11-15-68 11:30 A M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Glen Burnie	
9. DATE OF BIRTH 3-27-03		10. AGE (In years lost birthday) 64 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical		15. MOTHER'S MAIDEN NAME UNKNOWN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 191-22-0400	
18. INFORMANT MRS Louise BATES		ADDRESS SAME AS 5	
19. 412.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiovascular disease	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 443X		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 19 Nov 68	
24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR KIRKLEY FUNERAL HOME		ADDRESS Glen Burnie	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Valerie Mack		2. DATE AND HOUR OF DEATH 3:50 am 11/13/68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1-D		5. AGE (In years lost birthday) 56	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hosp 4940 EASTERN AVENUE, BALTIMORE, MD		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3102 FAIT AVENUE		F. INSIDE CITY LIMITS? #21224			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-12	9. AGE (In years lost birthday) 56	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME APOLINARY Lisowski		14. MOTHER'S MAIDEN NAME JADWIGA Mikulski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. CAROLINE CARBONE RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.91 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Heart Attack		CAUSE OF DEATH (A) IMMEDIATE CAUSE Heart Attack DUE TO, OR AS A CONSEQUENCE OF: (B) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF: (C) Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours	
19. DATE OF OPERATION 4-20-1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 11/13/68 to 11/13/68 that (I) (we) lost saw the deceased alive on 11/13 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Mark Dowow	
23B. DATE SIGNED 11/13/68		23C. PHYSICIAN'S NAME (Type) M ARK Dowow		23D. ADDRESS Balt City Hosp 4940 EASTERN AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/16/1968		24C. NAME OF CEMETERY or CREMATORY Holy ROSARY CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Jankura	
25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		25D. ADDRESS 2525 FLEET ST.			

Wojciech Lisowski

Janina Maria

Wojciech Lisowski
Janina Maria

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11549 CERTIFICATE OF DEATH

REG. NO. 68-11549

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JULIAN ANTONIAK		2. DATE AND HOUR OF DEATH NOV. 13 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 102			
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3005 EASTERN AVE.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3005 EASTERN AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-1886	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-01-8753A		17. INFORMANT MR. JULIAN ANTONIAK			
				ADDRESS 3005 EASTERN AVE			
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anger's Heart Failure				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Hypertension 7/5 yrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 422.1 II				(B) DUE TO, OR AS A CONSEQUENCE OF: Gen ASCVD - Ch. Lung Dis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-11-68 to 11-13-68 that (I) (we) last saw the deceased alive on 11-11-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Theodore T. Blazynski				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11-15-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 4229 S. Charles St 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/16/1968		24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Jodkowski		25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		ADDRESS 2525 FLEET ST.	

Journal of the Rev. Henry Carter, M.A.,
Bishop of the Diocese of London, 1841-1842.

1841-1842. The Rev. Henry Carter, M.A.,
Bishop of the Diocese of London, 1841-1842.

1841-1842. The Rev. Henry Carter, M.A.,
Bishop of the Diocese of London, 1841-1842.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11550

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ORTHELIA JONES

2. DATE
OF
DEATHKnown ☒
Estimated ☐Month
Day
YearDay
Year
HourYear
HourHour
M.

11

12

68

4:15 p

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 12, 1968

4:15 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☒ NO ☐

E. STREET AND NUMBER

628 LaFayette Ave.

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

Female

Colored

9. DATE OF BIRTH

10. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

10-21-08

60

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Shady Grove, Ala.

U.S.A.

John Jones

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Retired

Government

Anna Mark

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

None

Cleveland Jones - 901 5th Street NE

19. 250.9

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxiation, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

~~XXXXXXXXXXXXXXXXXXXX~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Diabetes mellitus

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK m. AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 13, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

11-16-68

Carver Memorial Park

Prince George, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 18 1968

Robert E. Jenkins

John I. Rhines Company Funeral Home
3015 12th Street, N. E.

John F. White

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

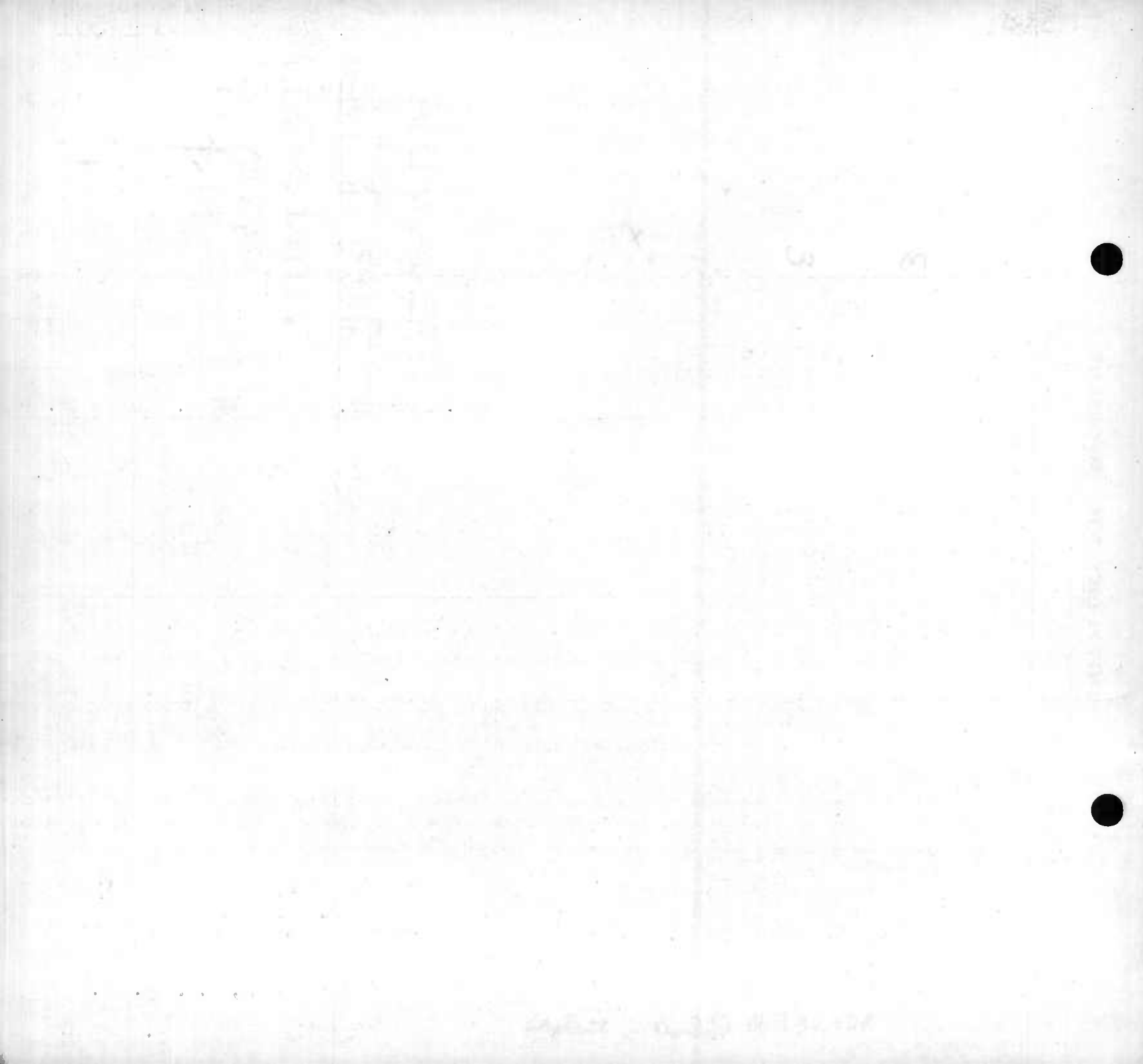
68-11551

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11551

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William E. Foster</i>		2. DATE AND HOUR OF DEATH <i>11/16/68 1:25 PM</i>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>SOUTH BALTIMORE GENERAL HOSPITAL</i> <i>43</i>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>BALTIMORE</i>	
				E. STREET AND NUMBER <i>137 E. Clement St.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-18-10</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Steel</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>
13. FATHER'S NAME <i>Edward Foster</i>				14. MOTHER'S MAIDEN NAME <i>Annie Handschuh</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs. Audrey A. Foster 137 E. Clement St.</i>		
18. <i>451.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary Embolism</i> (B) <i>Thrombophlebitis</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>2 weeks</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>464X II</i>				Pneumonic heart dis., CVA (L)			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10-20-</i> <i>19 68</i> to <i>11-16</i> <i>19 68</i> , that (I) (we) last saw the deceased alive on <i>125 AM 11-16</i> <i>19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>C. G. Baumann</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11-16-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>C. G. BAUMANN M.D.</i>				23D. ADDRESS <i>SOUTH BALTIMORE GENERAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11 19 68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven</i>		24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, A.A. Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 18 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Tscheyna</i>		25C. FUNERAL DIRECTOR <i>McCully</i>		ADDRESS <i>130 E. Fort Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

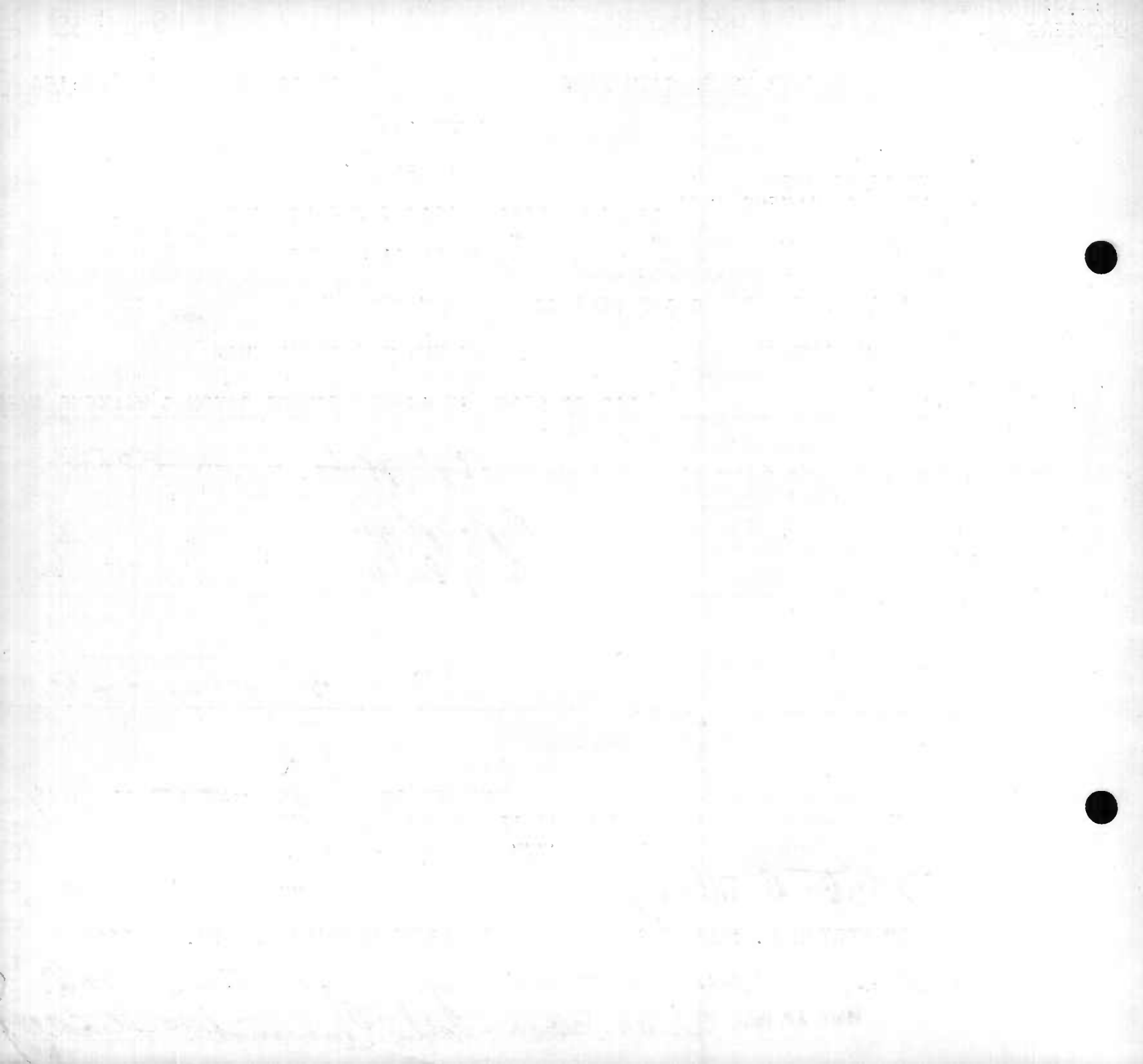
68-11552 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-11552

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Michael J. Donahue		2. DATE AND HOUR OF DEATH 11-13-68 12:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
				E. STREET AND NUMBER 3510 White Ave	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-13-96	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I		16. SOCIAL SECURITY NO. 213-09-0706		17. INFORMANT WIFE	
				ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 412.31X177X		CAUSE OF DEATH (A) IMMEDIATE CAUSE Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 420.0 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Carcinoma of Prostate			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 11-10-1968 to 11-13-1968 , that (1) (we) last saw the deceased alive on 11-13-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen Goldberger MD.				23B. DATE SIGNED 11-13-68	
23C. PHYSICIAN'S NAME (Type) STEPHEN GOLDBERGER MD.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL 2511-D Steel Rd Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/15/68		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION BALTO MD		24E. DATE REC'D BY HEALTH DEPT. NOV 18 1968		24F. NAME OF REGISTRAR Robert E. Johnson	
24G. FUNERAL DIRECTOR Paula Beruame		24H. ADDRESS 6067 Hwy			

B-346		68-11553		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-11553				
BIRTH NO.					1. NAME OF DECEASED (Type or Print)							
BUTLER, HELEN CATHERINE					2. DATE AND HOUR OF DEATH 11/13/68 9:15A.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSP CATON & WILKENS AVES BALTO MD 21229					C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>							
E. STREET AND NUMBER 4730 FREDERICK AVE												
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 07 27 93		9. AGE (In years lost birthday) 75				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TELE OPR		10B. KIND OF BUSINESS OR INDUSTRY C & P TELE CO		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME JOHN BUTLER					14. MOTHER'S MAIDEN NAME CATHERINE CUNNINGHAM							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 03 6617		17. INFORMANT ST AGNES RECORDS CATON & WILKENS AVES								
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 1871.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 2 weeks ~ 2 weeks ~ 2 months							
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes - St. Agnes Hospital			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR?			(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 10 19 68 to NOVEMBER 13 19 68, that (X) (we) last saw the deceased alive on NOVEMBER 13 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.												
23A. SIGNATURE Morton B. Blumberg					23B. DATE SIGNED 11/13/68		23C. PHYSICIAN'S NAME (Type) DR MORTON B. BLUMBERG			23D. ADDRESS ST AGNES HOSPITAL BALTO. MD 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-18-68		24C. NAME OF CEMETERY or CREMATORY Cathedral Cemy.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE RECEIVED BY HEALTH DEPT. NOV 18 1968			25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Morton B. Blumberg		25D. ADDRESS Caton & Wilkens Aves										



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11554

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM H. OWENS, Jr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1909 Harman Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour November 13, 1968 6:45 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12-3-1914		10. AGE (In years lost birthday) 53	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Captain		14B. KIND OF BUSINESS OR INDUSTRY U. S. Army	
15. MOTHER'S MAIDEN NAME Florence V. Truitt		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes	
17. SOCIAL SECURITY NO. 212-07-0501		18. INFORMANT ADDRESS Miss Nancy Owens, 1075 Wilmington Ave. 21223	
19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
20. DATE OF OPERATION 2		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 14, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-18-68	
24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore City, Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Hubbard	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

THE NEW YORK PUBLIC LIBRARY

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11555

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11555

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HENZLER, ROBERT JAMES

2. DATE AND HOUR OF DEATH

NOVEMBER 15, 1968 4:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

ST AGNES HOSPITAL
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
WILKENS & CATON AVENUES

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND B. COUNTY BALTIMORE 53-00 21229

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

E. STREET AND NUMBER

206 WESTSHIRE ROAD

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

01 22 03

9. AGE (In years last birthday)

65

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Office Manager

10B. KIND OF BUSINESS OR INDUSTRY

American Oil Co.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Harriett E. (Unknown)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216 03 9932

17. INFORMANT

RECORD'S BALTIMORE MD 21229

ADDRESS

ST AGNES HOSPITAL WILKENS & CATON AVE

18. 436.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

11 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) HYPERTENSION

DUE TO, OR AS A CONSEQUENCE OF:

5 YEARS

(C).....

MEDICAL CERTIFICATION

331X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from OCTOBER 31, 1968 to NOVEMBER 15, 1968, that (X) (we) last saw the deceased alive on NOVEMBER 15, 1968 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James G. Kane M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

11 15 68

23C. PHYSICIAN'S NAME (Type)

JAMES G. KANE, M.D.

23D. ADDRESS

BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-18-68

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore City, Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 18 1968

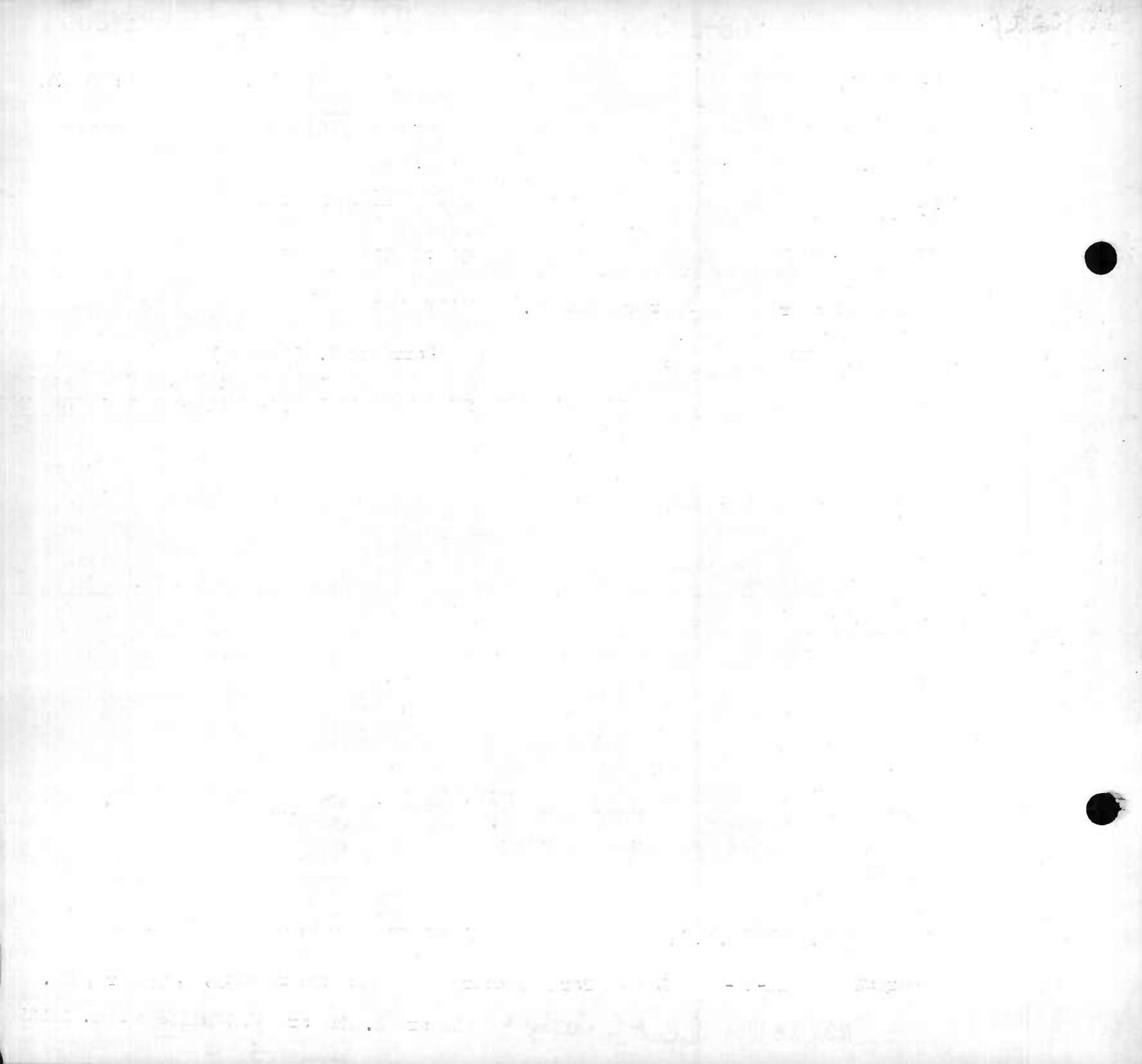
25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

Howard H. Hubbard 4107 Wilkens Ave. 21229

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11556 CERTIFICATE OF DEATH

REG. NO. 68-11556

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Harry S. Gordon</i>		2. DATE AND HOUR OF DEATH <i>11/13/68 9:15 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland</i> <i>38</i>			C. CITY OR TOWN <i>Lansdowne</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			E. STREET AND NUMBER <i>2418 Smith Avenue 21227</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-6-1902</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bull Dozer Operator</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Jack Stedding Co.</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>George B. Gordon</i>			14. MOTHER'S MAIDEN NAME <i>Virginia Parker</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-03-4832</i>	17. INFORMANT <i>Elsie M. Gordon</i> ADDRESS <i>21227 2418 Smith Ave. Lansdowne Md</i>		
18. <i>430.7 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Ruptured aneurysm, basilar artery</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>330X II</i>			(B) <i>Atherosclerotic vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>yrs.</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C) _____		
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/13 1968</i> to <i>11/13 1968</i> , that (I) (we) last saw the deceased alive on <i>11/13 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Louis E. Grenzer</i>			23B. DATE SIGNED <i>11/13/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Louis E. Grenzer</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>11-18-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore City, Baltimore Md.</i>			25A. DATE REC'D BY HEALTH DEPT. <i>NOV 18 1968</i>		
25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>			25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i> ADDRESS <i>4107 Wilkens Ave. 21229</i>		

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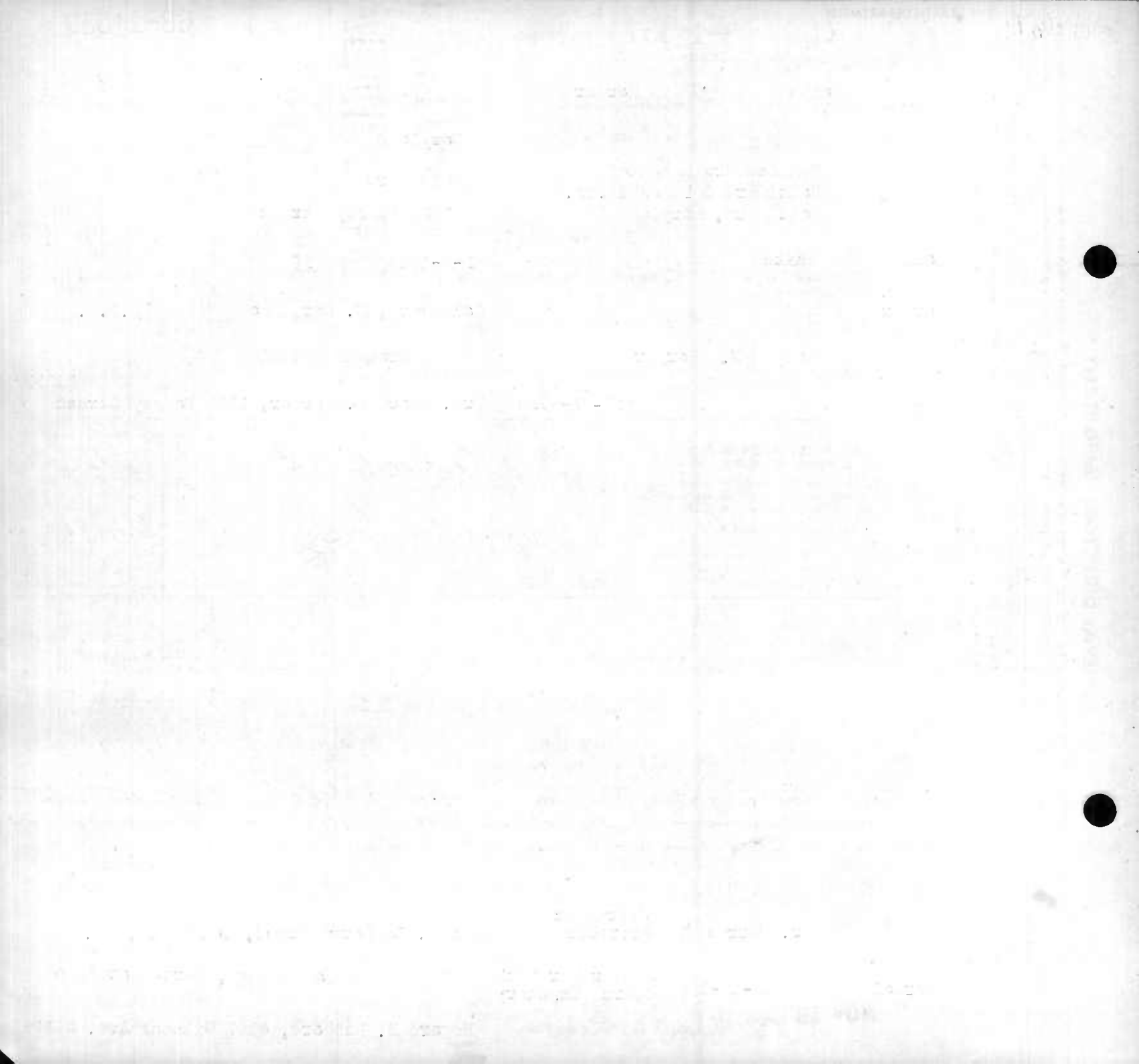
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11557 BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 68-11557

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Ralph E. Harper		2. DATE AND HOUR OF DEATH 11-15-68 3 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital Baltimore & Pulaski Sts. Baltimore, Maryland		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-4-1918		9. AGE (In years lost birthday) 50		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Salisbury, N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ralph F. Harper		14. MOTHER'S MAIDEN NAME Frances Steel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 237-03-6756		17. INFORMANT Mrs. Pearl Z. Harper, 2228 Ramsey Street	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest (B) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF: (C) Since 1961		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 14 1968 to Nov. 15 1968 , that (I) (we) last saw the deceased alive on Nov. 14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Morris B Schreiber DEGREE				23B. DATE SIGNED 11-15-68	
23C. PHYSICIAN'S NAME (Type) Dr. Morris B Schreiber DEGREE				23D. ADDRESS 1519 W. Lombard Street, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-19-1968		24C. NAME OF CEMETERY or CREMATORY Southriver Methodist Church Cemetery	
24D. LOCATION (City, town, or county) (State) Rowan County, North Carolina		25A. DATE RECEIVED BY HEALTH DEPT. NOV 18 1968			
25B. NAME OF REGISTRAR Robert E. Schreiber		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



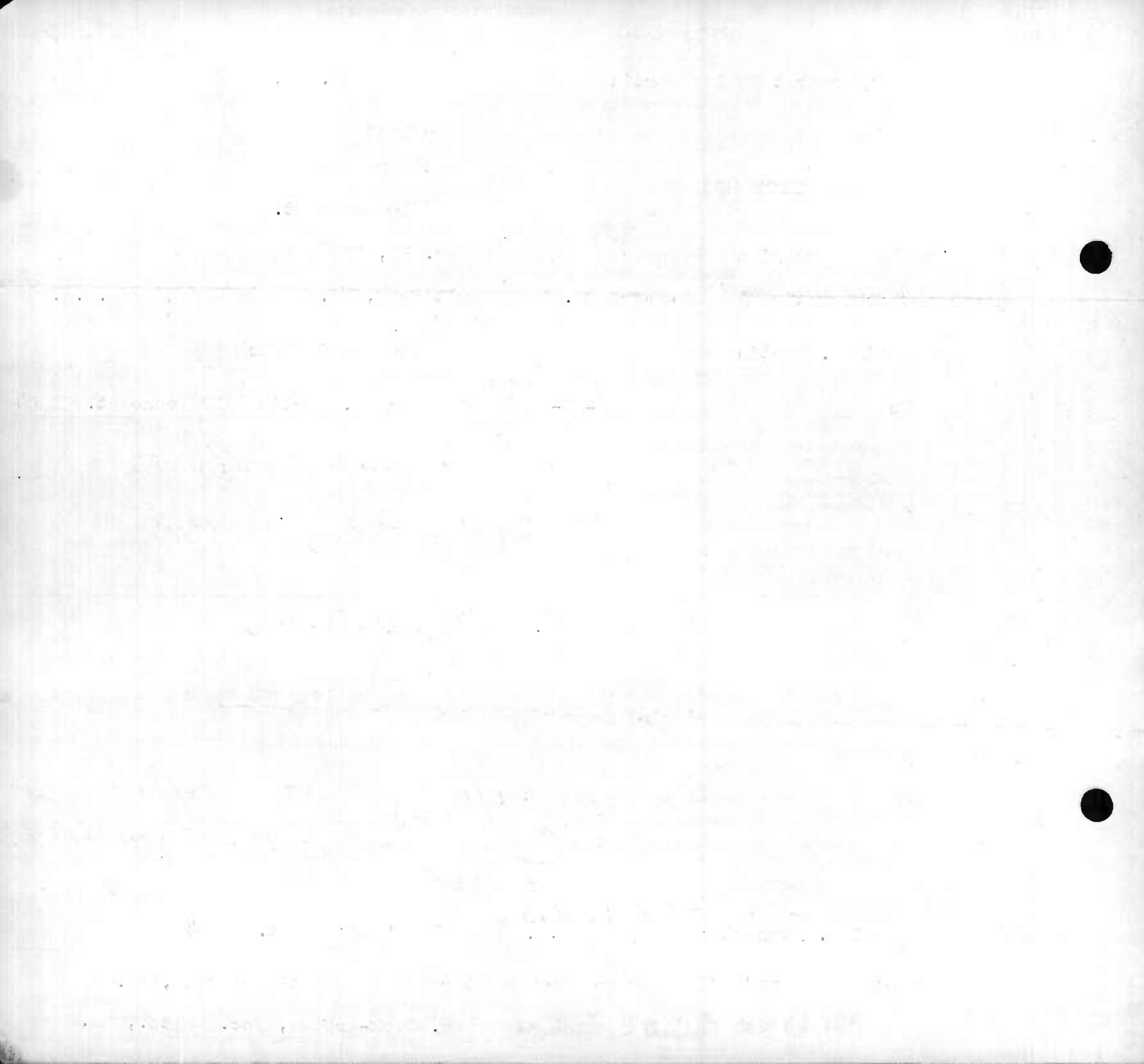
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11558 CERTIFICATE OF DEATH

REG. NO. 68-11558

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Margaret Louise Martin		2. DATE AND HOUR OF DEATH Nov. 10, 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITAL				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 6310 Toone St.			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 17, 1908	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)		10B. KIND OF BUSINESS OR INDUSTRY Laundry Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis W. Martin				14. MOTHER'S MAIDEN NAME Anna Amelia Lynch			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-2274		17. INFORMANT Miss Lena W. Martin 6310 Toone St. 21224			
18. 410.9x1250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arter. Coronary Artery Thrombosis				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II Diabetes Mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/10 19 67 to 10/18 19 68 , that (I) (we) last saw the deceased alive on 10/18 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Pt. taken to City Hospital E.R. Med. Examining Unit							
23A. SIGNATURE Paul G. Koukoulas				23B. DATE SIGNED 11/12/68		23C. PHYSICIAN'S NAME (Type) Paul G. Koukoulas M.D.	
23D. ADDRESS 6511 O'Donnell St. 21225							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/13/68		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore City, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Furlong		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. Balto., Md.		ADDRESS	



L-200

68-11559 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11559

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILL C. LEWIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 17 68 10:25 p	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour November 17, 1968 10:25 p.m.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Balto.	
7. RACE Colored		C. CITY OR TOWN Balto.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 7-29-1953		10. AGE (In years lost birthday) 15	
11. BIRTHPLACE (State or foreign country) BALTIMORE, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM LEWIS		14. MOTHER'S MAIDEN NAME Ruby Mc GLOCKIN	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Ruby Lewis		ADDRESS 2131 N. FULTON AVE	
19. E864X		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Ingestion of ethylene glycol DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E882.0		(C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2131 N. Fulton St.		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 11 17 68 ?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Accidentally ingested	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED November 13, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-21-68	
24C. NAME OF CEMETERY OR CREMATORY BALTO. NAT. CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Marshall W. Jones, JR.		ADDRESS 1735 HOLFORD AVE	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11560

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

COWAN, GEORGE
REG. NO. 01/25/68-11560

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GEORGE COWAN		11-17-68 12:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1627 E. 30TH STREET	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	NEGRO		1-10-26	43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country)	
NONE				S.C.	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
RALPH COWAN		ROSA WEBB			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES 9-7-50-9-15-52		220-24-2195		DOROTHY COWAN 1627 E. 30TH ST 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE RESPIRATORY ARREST + HYPO- TENSION WITH METABOLIC ACIDOSIS 48 HRS (B) LAENNEC'S CIRRHOSIS + GRAM NEG SEPSIS 48 HRS DUE TO, OR AS A CONSEQUENCE OF: (C) SEVERE MALNUTRITION 3 MON.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		MEGALOBLASTIC ANEMIA 3 MON.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Nov. 15 19 68 to Nov. 17 19 68, that (1) (we) last saw the deceased alive on Nov. 17 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Douglas T. Fearon, M.D.		Nov. 17, 1968			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DOUGLAS T. FEARON, M.D.		The Johns Hopkins Hosp. Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL	11-20-68	BALTIMORE NATIONAL		BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 19 1968		Robert E. Fearon		JOSEPH KNIGHT 1639 N. BROADWAY	

x

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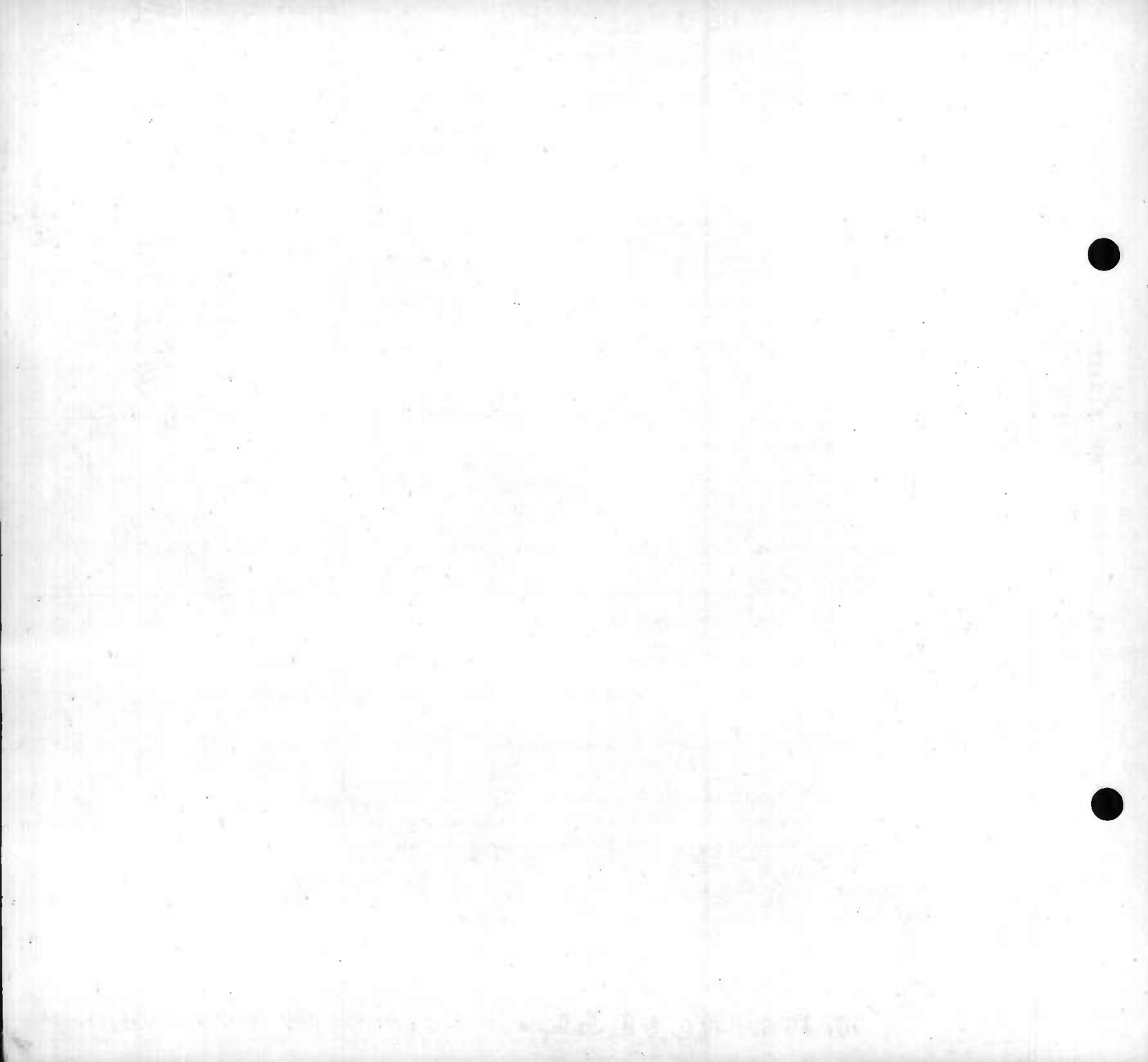
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11561 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-11561

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>McKAY, RUFUS</u>		2. DATE AND HOUR OF DEATH <u>11-16-68</u> <u>3¹⁰</u> <u>A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md</u> B. COUNTY <u>City</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South BALTIMORE GENERAL</u> <u>43 Hospital</u>				C. CITY OR TOWN <u>BALTIMORE</u> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1419 W.N. BROADWAY ST.</u>	
5. SEX <u>m</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-30-219</u>	9. AGE (In years last birthday) <u>49</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CHEURON ASPHALT</u>		11. BIRTHPLACE (State or foreign country) <u>FLA.</u>	
13. FATHER'S NAME <u>WALTER MOSES MCKAY</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>265-38-8368</u>	
17. INFORMANT <u>ANNETTA MCKAY</u>				ADDRESS <u>1419 N. BROADWAY</u>	
18. CAUSE OF DEATH <u>443 X II</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>443 X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <u>Cardiac arrest</u> <u>immediate</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cardiac arrhythmias</u> <u>6 days</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Hypertensive Cardiovascular disease</u> <u>unknown</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>November 7</u> 19 <u>68</u> to <u>November 16</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>November 16</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Raymond Gambrell 3d M.D.</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<u>BURIAL</u>		<u>11-21-68</u>		<u>BALTIMORE NATIONAL BALTIMORE Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<u>NOV 19 1968</u>		<u>Robert E. Taylor</u>		<u>JOSEPH H. KNIGHT 1639 N. BROADWAY</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11562

BIRTH NO.

1. NAME OF DECEASED **ASZLENE**
(Type or Print) **MARION A JASON**2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ **November 14, 1968** **1:18 P. M.**4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
OR INSTITUTION3. DATE PRONOUNCED DEAD Month Day Year Hour
November 14, 1968 **1:18 P. M.**5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY**00 3002 Thorndale Avenue**6. SEX **Female** 7. RACE **Negro**B. MARRIED ☒ NEVER MARRIED ☐
SEPARATED
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN
BaltimoreD. INSIDE CITY LIMITS
YES ☒ NO ☐9. DATE OF BIRTH
Jan. 8, 193410. AGE (In years lost birthday) **34**
If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.E. STREET AND NUMBER
3002 Thorndale Avenue11. BIRTHPLACE (State or foreign country)
Maryland12. CITIZEN OF
U.S.A.13. FATHER'S NAME
Walter A. Sims, Jr.14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
store clerk14B. KIND OF BUSINESS OR INDUSTRY
dept. store15. MOTHER'S MAIDEN NAME
Lamore Wilson16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No17. SOCIAL SECURITY NO.
215-32-115218. INFORMANT ADDRESS
Mrs. Walter A. Sims, Jr., New Windsor, Md19. **E965X**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)CAUSE OF DEATH
Shotgun wound of neck

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
Home22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
Bedroom-Basement Apt. 3002 Thorndale Ave.22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) **Nov. 14, 1968 1:15 P. M.**22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒22F. HOW DID INJURY OCCUR?
Shot by husband23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)**Ronald N. Kornblum, M.D.**CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 15, 196824A. BURIAL CREMATION, REMOVAL (Specify)
Burial

24B. DATE

Nov. 17, '68 Western Chapel Cem.

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)
New Windsor, RD#1, Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 19 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

J. E. Myers, Jr. Westminster, Md.

ADDRESS

1942

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MAILED

1942

NOV 15 1942

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68-11563 BALTIMORE CITY HEALTH DEPARTMENT

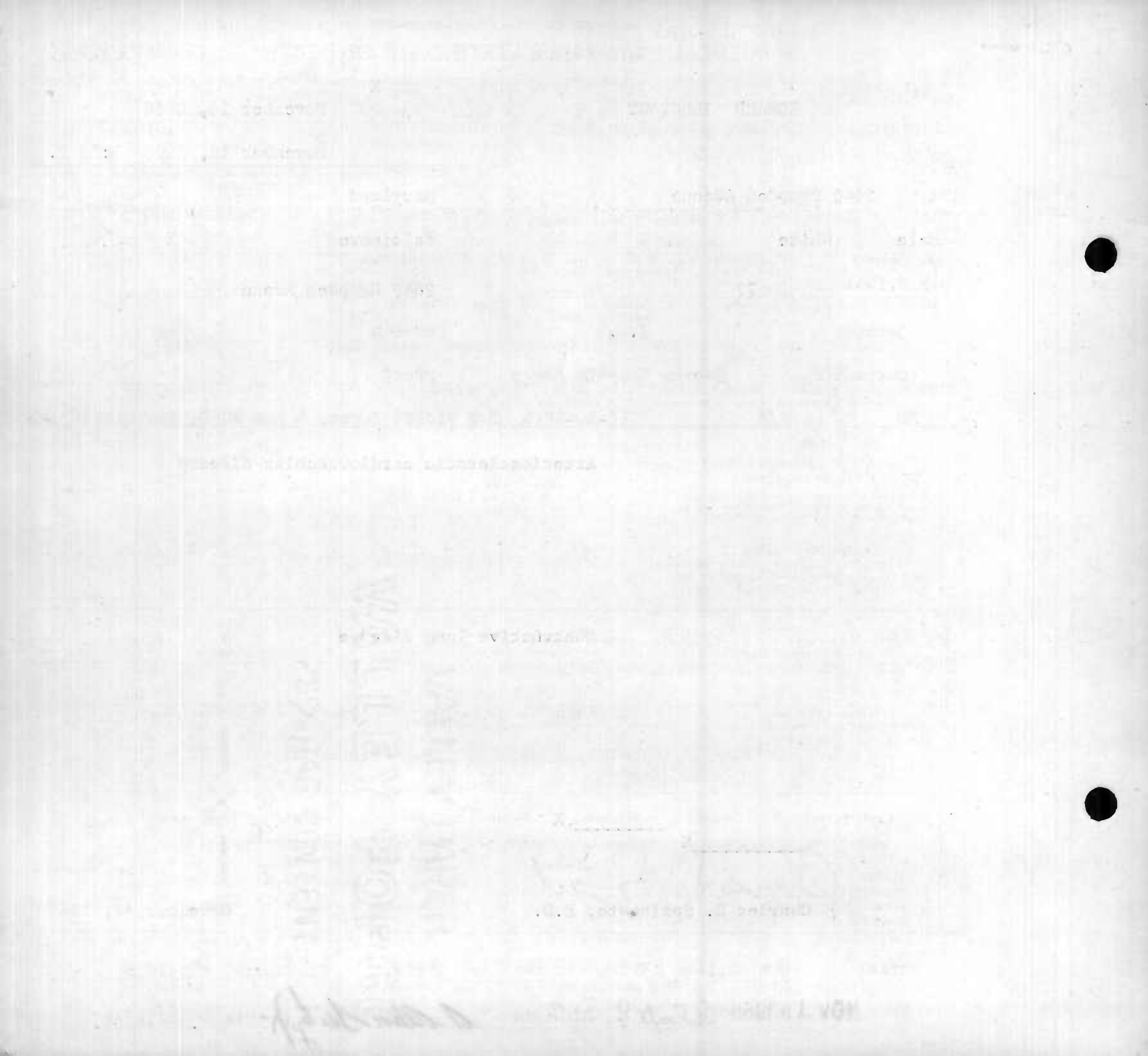
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11563

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD ILMSTADT				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 16, 1968 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 60 2649 Hampden Avenue				3. DATE PRONOUNCED DEAD Month Day Year Hour November 16, 1968 7:55 P.M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 2649 Hampden Avenue			
9. DATE OF BIRTH Mar 2, 1891		10. AGE (In years lost birthday) 77		11. BIRTHPLACE (State or foreign country) Germany			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			
15. MOTHER'S MAIDEN NAME Praff		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-10-0769		18. INFORMANT Mrs Violet Bowen, 3 Box 302D, Westminster, Md	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Obstructive lung disease				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) No							
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> November 17, 1968							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 20, 1968		24C. NAME of CEMETERY or CREMATORY Evergreen Memorial Gardens		24D. LOCATION (City, town, or county) (State) Finksburg, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR ADDRESS 814 W. 36th St.			

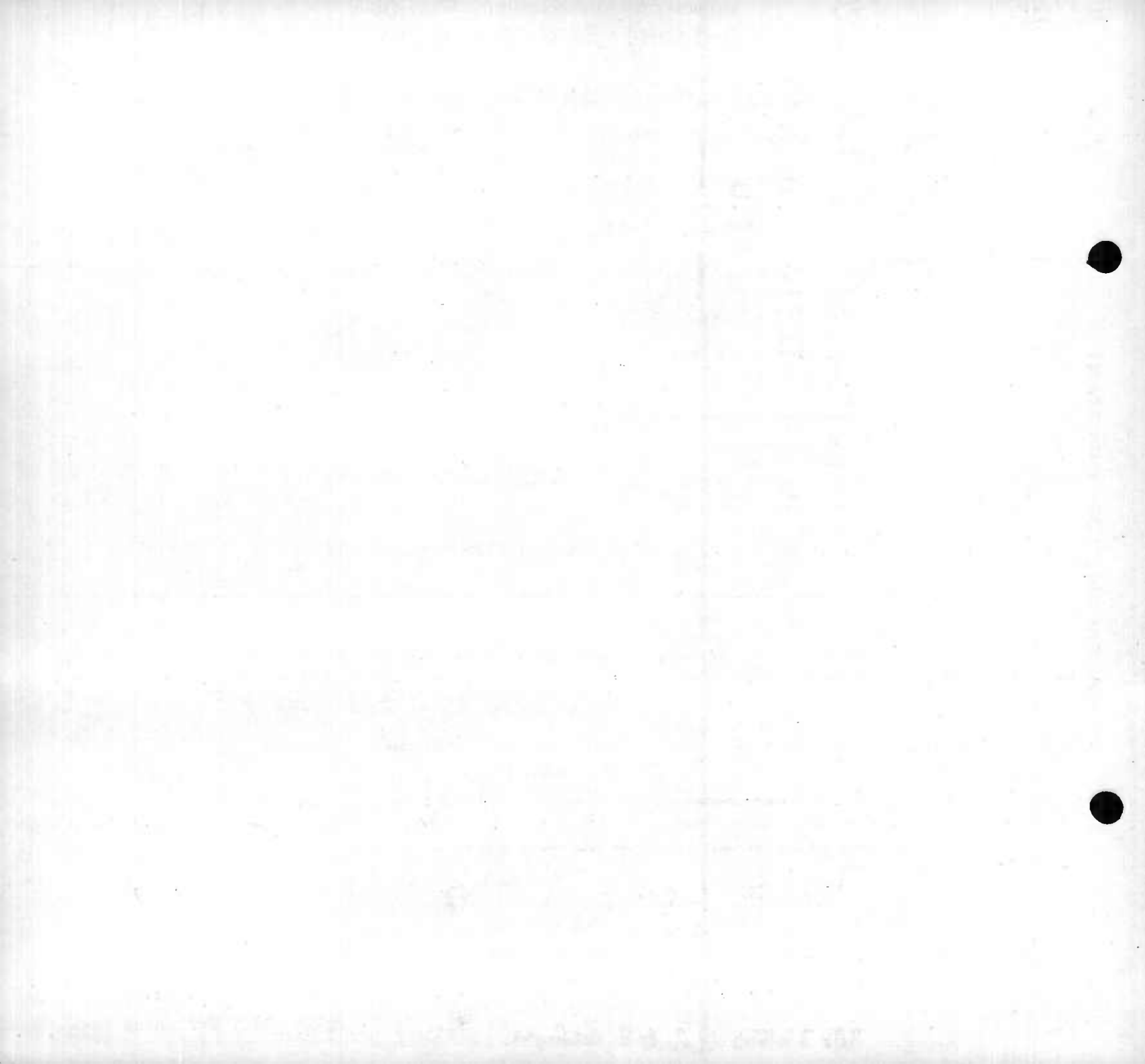


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11564 CERTIFICATE OF DEATH

REG. NO. 68-11564

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Charles Edward Frank, Sr.		2. DATE AND HOUR OF DEATH Nov. 16, 1968 9:45 p M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21212		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 44/99 Union Memorial Hospital DOA Balto. Md.		E. STREET AND NUMBER 5412 Lothian Road		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1895	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Immigration Service		10B. KIND OF BUSINESS OR INDUSTRY US Government		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Adam Frank		14. MOTHER'S MAIDEN NAME Cora Barber		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-38-8559A		17. INFORMANT ADDRESS Mrs. Audrey L.F. Chapman (Daughter) 1505 Cranwell Rd. Lutherville, Md. 21093	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ASCVD		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1956	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from NOVEMBER 19 58 to Nov 16 19 68, that (I) (we) last saw the deceased alive on OCT 18 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Dr. John M. Scott		23B. DATE SIGNED Nov. 18, 1968		23C. PHYSICIAN'S NAME (Type) Dr. John M. Scott	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 20, 1968		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Memorial Gardens	
24D. LOCATION Cockeysville, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Seitz	
25C. FUNERAL DIRECTOR Eugenia K. Seitz		25D. ADDRESS 5209 Work Road		25E. ADDRESS Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**BALTIMORE CITY HEALTH DEPARTMENT
68-11565 CERTIFICATE OF DEATH**

REG. NO. **68-11565**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Kilduff, William E.		2. DATE AND HOUR OF DEATH 11/14/68 1:45 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Balt. 63-00	
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital 48		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8/17/99		9. AGE (In years lost birthday) 69		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY Retired Carpenter		11. BIRTHPLACE (State or foreign country) Balt. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas E. Kilduff		14. MOTHER'S MAIDEN NAME Donovan		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 215-09-0444		17. INFORMANT Charles Kilduff		ADDRESS 2813 W. Indigo Ave. Balt. Md.	
18. 441.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Abdominal aortic aneurysm		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Abdominal aortic aneurysm (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 451X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 11/10/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal aortic aneurysm		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/6 19 68 to 11/14 19 68 , that (I) (we) last saw the deceased alive on 11/14 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. W. Paulk, M.D.		23B. DATE SIGNED 11/14/68		23C. PHYSICIAN'S NAME (Type) J. W. Paulk, M.D.	
23D. ADDRESS Baltimore, Maryland		23E. FUNERAL DIRECTOR John C. Miller Inc. 6415 Belair Rd. - 21206			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-81-68		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION Baltimore, Maryland		24E. ADDRESS 6415 Belair Rd. - 21206			
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John C. Miller Inc. 6415 Belair Rd. - 21206	

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Thomas E. Kilbrick

Donovan

Dis-covery

Robert Kilbrick

no

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

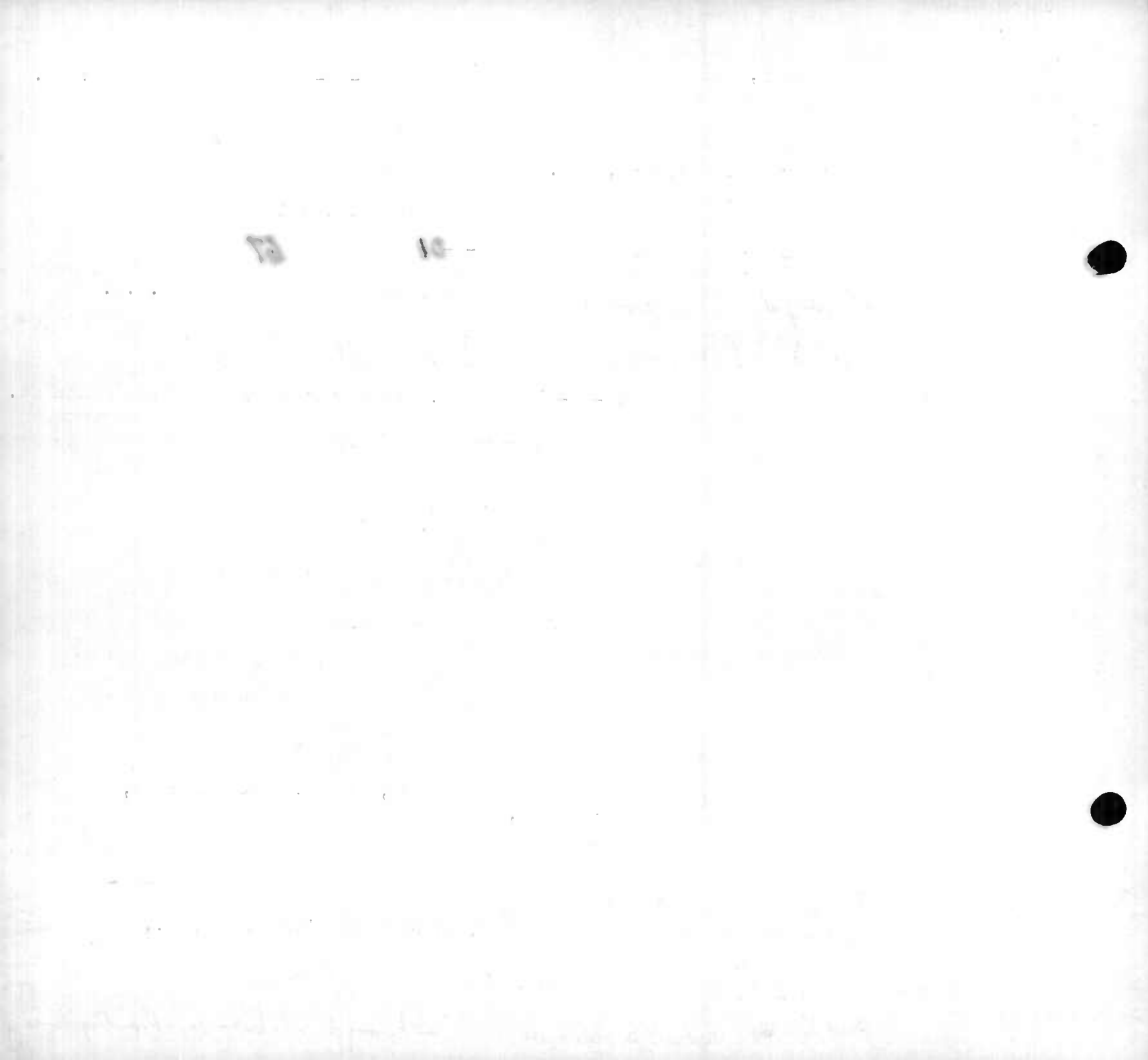
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11566
68-11566				CERTIFICATE OF DEATH	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Russell, John Henry JR</i>			2. DATE AND HOUR OF DEATH <i>11-14-68 3:15 PM</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Nursing Home</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>27-N. Carey St</i>			E. STREET AND NUMBER <i>5906 Fredrick Rd</i>		
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-11-1885</i>	9. AGE (In years last birthday) <i>83</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Accomack Co Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>unknown John Russell Sr</i>			14. MOTHER'S MAIDEN NAME <i>unknown Betty</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-8785</i>	17. INFORMANT <i>Margaret Buck</i>		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>185X I</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>CA of Prostata</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
177X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>11-14</i> 19 <i>68</i> to <i>11-14</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-14</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John H. Russell, M.D.</i>			23B. DATE SIGNED <i>11-14-68</i>		
23C. PHYSICIAN'S NAME (Type) <i>Dr. John H. Russell</i>			23D. ADDRESS <i>1801 Greenberry Rd</i>		
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>11-18-68</i>	24C. NAME OF CEMETERY or CREMATORY <i>Mount Auburn Cent</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>		
25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 19 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>	25C. FUNERAL DIRECTOR <i>E. Craig O. Johnson</i>		ADDRESS <i>514</i>

12. ~~12.12.12~~

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11567 CERTIFICATE OF DEATH REG. NO. 68-11567			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Brown, Mae	
2. DATE AND HOUR OF DEATH 11-14-68 11:25p.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION 39		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc.	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 11-04		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1111 Tiffany Court	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-01
9. AGE (In years lost birthday) 67		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. Morgan		14. MOTHER'S MAIDEN NAME Ida. U. Morgan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-12-9137T	
17. INFORMANT Mrs. Doris Brown-daughter		ADDRESS 261 Mason Ct.	
18. 412.21x250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) Cardio-respiratory failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 443X II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: atrial fibrillation	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardiovascular Disease	
		(C) Diabetes mellitus	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 30, 1968 to November 14, 1968 , that (I) (we) lost saw the deceased alive on November 14, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE TERESITA A. CACHA, M.D.		23B. DATE SIGNED 11-15-68	
23C. PHYSICIAN'S NAME (Type) TERESITA A. CACHA, M.D.		23D. ADDRESS 1514 Division Street Balto., Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 19, 1968	
24C. NAME OF CEMETERY or CREMATORY MT. Auburn C.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Henry D. Wilson		ADDRESS 1000 Brantley Ave.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11568

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LOUIS McGRADY

(McCreedy)

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

11:00p M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

D.O.A.

Johns Hopkins Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 17, 1968

11:00 pm

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Nov. 7, 1949

10. AGE (In years
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1822 Chapel St.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Morris McCreedy

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

None

15. MOTHER'S MAIDEN NAME

Helen Thompson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Alice Fenster

ADDRESS

Same

19. E920X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Gunshot wound of the aorta:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Castle and Lanvale St.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

11 17 68 10:30p

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject shot by police officer

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 18, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Nov. 21, 1968

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 19 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

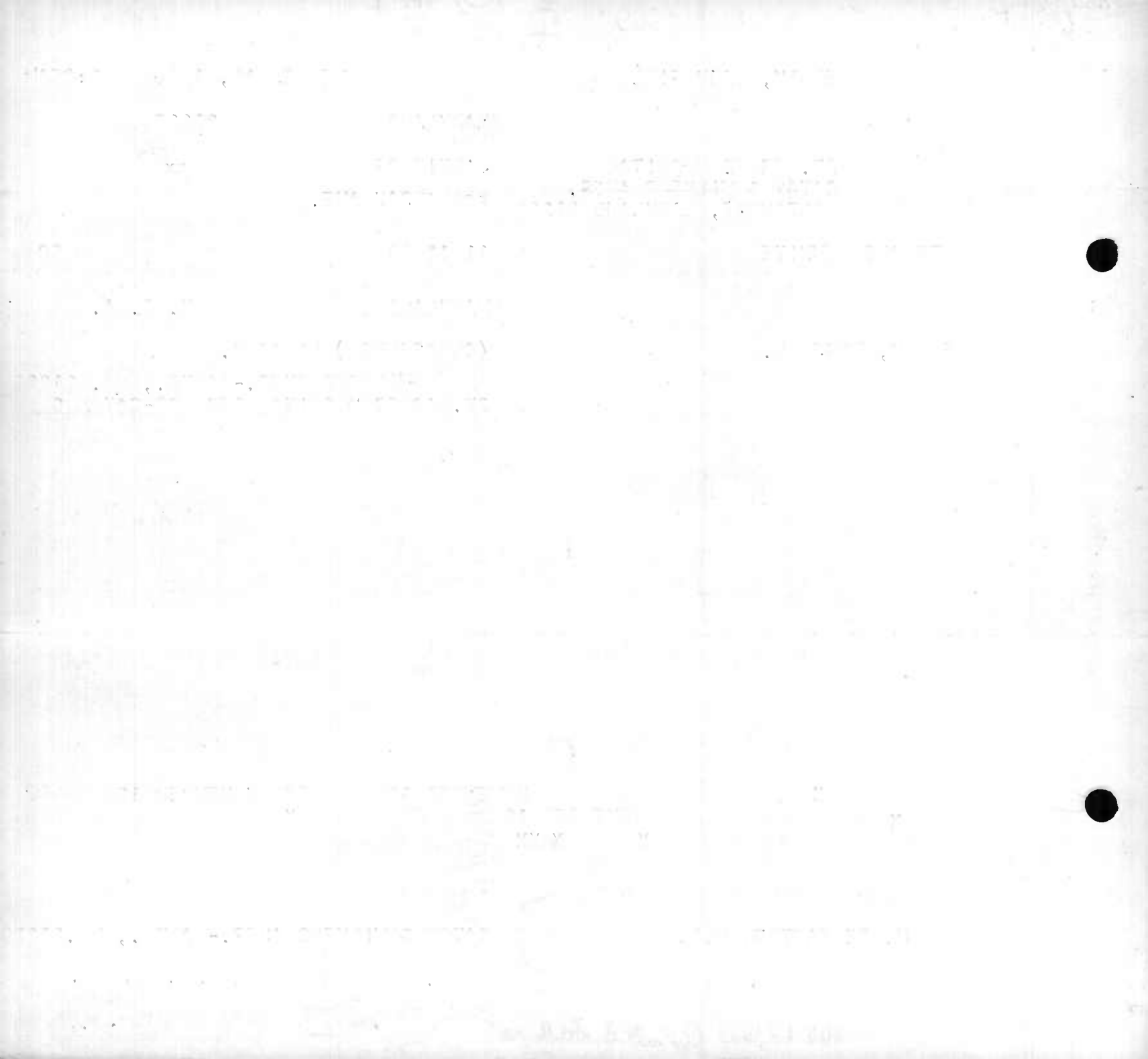
Edward F. Wilson 1000 Brantley Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) A fracture of any kind; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11569
BIRTH NO. <u>68-21553</u>					
1. NAME OF DECEASED (Type or Print) EMORY, BABY GIRL			2. DATE AND HOUR OF DEATH NOVEMBER 12, 1968 2:05AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229			A. STATE MARYLAND B. COUNTY 21225		
C. CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 509 ARSAN AVE.					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 12 68	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME EMORY, ROGER L.			14. MOTHER'S MAIDEN NAME (CLODFELTER) LINDA D.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT WILKENS AVES.-BALTO., MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &	
18. 777X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 776X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE Immaturity 29 weeks gestation, Premature labor DUE TO, OR AS A CONSEQUENCE OF: (B) Immaturity DUE TO, OR AS A CONSEQUENCE OF: (C) Immaturity		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOVEMBER 12 19 68 to NOVEMBER 12 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on NOVEMBER 12 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE M. DE CASTRO, M.D.				23B. DATE SIGNED 11/12/68	
23C. PHYSICIAN'S NAME (Type) M. DE CASTRO, M.D.				23D. ADDRESS CATON & WILKENS AVES.-BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 13, 1968		24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Pk.	
24D. LOCATION Glen Burnie, A. A. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR George J. Gonce	
25D. ADDRESS 4001 Ritchie Hwy.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11570 CERTIFICATE OF DEATH

REG. NO. 68-11570

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Estelle E. Holmes</i>		2. DATE AND HOUR OF DEATH <i>11-18-68</i> <i>10³⁰</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1430 Riverside Ave.</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 15, 1906</i>	9. AGE (In years lost birthday) <i>62</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>Harry F. Rudolph</i>		14. MOTHER'S MAIDEN NAME <i>Delia C. Long</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Harry Rudolph</i> ADDRESS <i>2001 Woodburn Ave.</i>	
18. <i>450.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Subarachnoid hemorrhage</i> (B) <i>Ruptured intracerebral aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Arterial Hypertension</i> (C) <i>Renal Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>330X II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>11/18/68</i> to <i>11/18/68</i> 19 <i>68</i> and that (I) (we) last saw the deceased alive on <i>11/18/68</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Manuela M. Ribeiro, M.D.</i>		23B. DATE SIGNED <i>11/18/68</i>		23C. PHYSICIAN'S NAME (Type) <i>MANUELA M. RIBEIRO, M.D.</i>	
23D. ADDRESS <i>Mercy Hospital</i>		23E. NAME OF CEMETERY or CREMATORY <i>Cathedral</i>		23F. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11 21 68</i>		24C. NAME OF REGISTRAR <i>Robert E. Jackson</i>	
24D. DATE REC'D BY HEALTH DEPT. <i>NOV 19 1968</i>		24E. NAME OF REGISTRAR <i>Robert E. Jackson</i>		24F. FUNERAL DIRECTOR <i>Mc Gully</i> ADDRESS <i>130 E. Fort Ave.</i>	

General Practice
Internal Medicine
Pediatrics
Subspecialty/Consultant

11/18/18 11/18/18

11/18/18
James M. Ribeiro, MD
James M. Ribeiro, MD

FUNERAL DIRECTOR: IMPORTANT

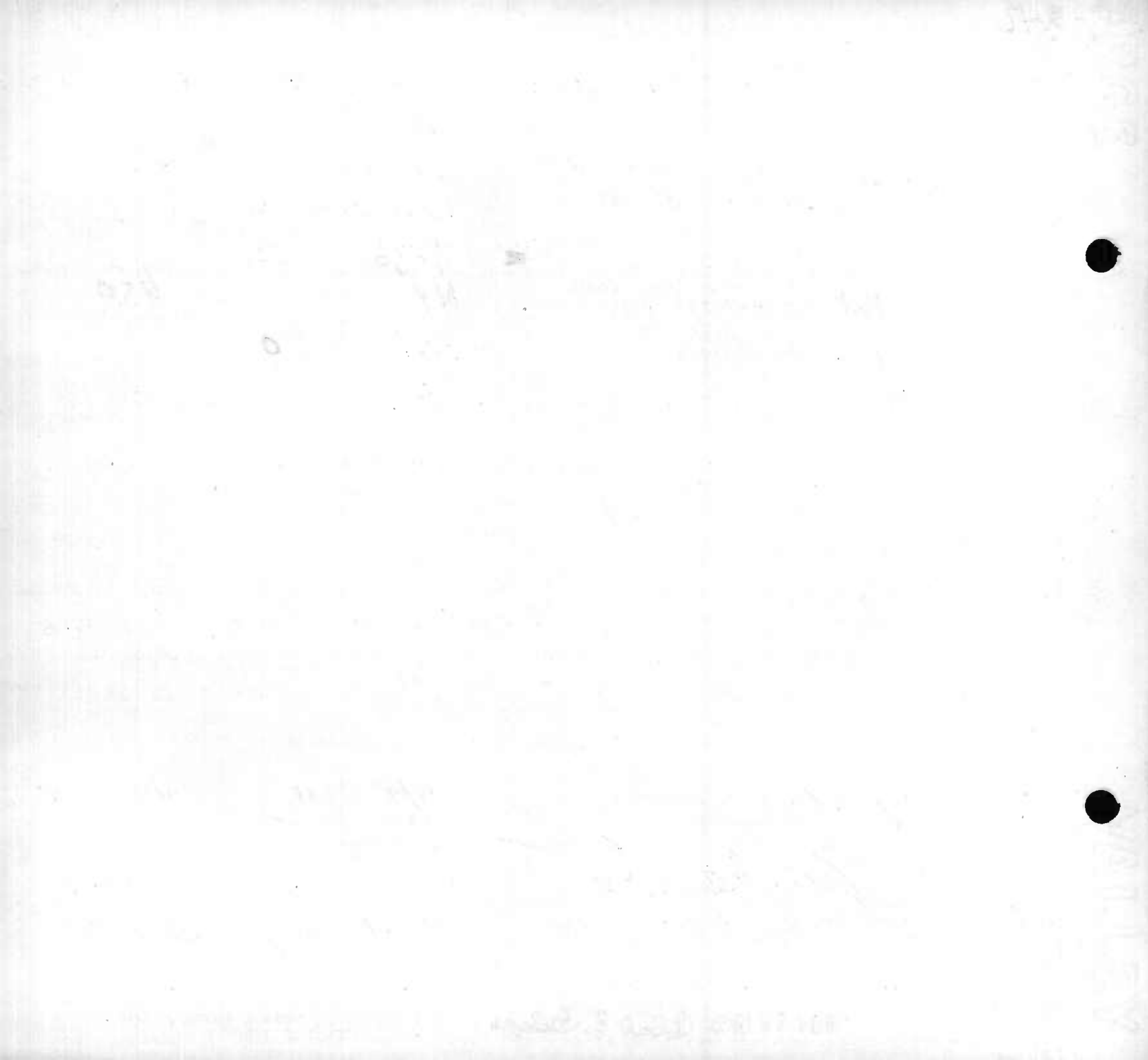
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 68-11571

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Theresa Ella Rockwell</i>		2. DATE AND HOUR OF DEATH <i>Nov 17, 1968 6:10 P M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>26-03</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>U.S. Public Health Service Hospital Wyman PK Drive 31st St</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse-North Shore Hosp.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>New York</i>		8. DATE OF BIRTH <i>7/27/30</i>	
13. FATHER'S NAME <i>James O Miller</i>		14. MOTHER'S MAIDEN NAME <i>Pauline Mielko</i>		9. AGE (In years last birthday) <i>38</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>058 28 2487</i>		11. BIRTHPLACE (State or foreign country) <i>N.Y.</i>	
17. INFORMANT <i>Records-US PHS Hosp</i>		ADDRESS <i>Balt, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
18. <i>174X I</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CARCINOMATOSIS</i>		<i>1 Mos</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
170X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>CARCINOMA of BRPAST</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(H)</i> (this hospital) attended the deceased from <i>10/7 1968</i> to <i>11/17 1968</i> , that <i>(H)</i> (we) lost saw the deceased alive on <i>11/17 1968</i> and that in <i>(our)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(I)</i> <i>(We)</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jeffrey A Gottlieb MD</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11/17/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Jeffrey A Gottlieb MD</i>		23D. ADDRESS <i>U.S PHS Hosp Balt, Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/21/68</i>		24C. NAME of CEMETERY or CREMATORY <i>Gardens of Faith Cem.</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. NAME of REGISTRAR <i>Robert E. Jenkins</i>		24F. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 19 1968</i>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>3331 Brehms Lane</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11572 CERTIFICATE OF DEATH

REG. NO. 68-11572

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Ethyl V. Green</u>		2. DATE AND HOUR OF DEATH <u>Nov 16, 68</u> <u>11 20</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> , B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3221 Dudley Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/9/89</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Kaline Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Fountain</u>			
14. MOTHER'S MAIDEN NAME <u>Rebecca Hilderbrandt</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>215-03-1032A</u>		17. INFORMANT <u>Edna Fountain (sister) above</u>			
18. CAUSE OF DEATH <u>0559 I</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>? weeks</u>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>septicemia</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>0559 4 II</u>		<u>CV A</u>			
19A. DATE OF OPERATION <u>2 None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>TP</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>11-12</u> 19 <u>68</u> to <u>11-16</u> 19 <u>68</u> , that <u>I</u> (we) last saw the deceased alive on <u>11-16</u> 19 <u>68</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>I</u> (We) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Brian Block</u>		23B. DATE SIGNED <u>16 NOV 68</u>		23C. PHYSICIAN'S NAME (Type) <u>Brian Block</u>	
23D. ADDRESS <u>Union Memorial Hosp</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>11/19/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 19 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>	
				ADDRESS <u>3331 Brehms Lane</u>	

University of Maryland Hospital

University of Maryland

Baltimore

3321 Bayview Ave

4/1/88

24

Maryland

George Washington

George Washington

212-01-0000

Edna Foundation (11/11/88)

September

CA 4

None

None

For

W

11-12

83

11-12

0

0

From Black

me

Under Maryland Map

10/11/88

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED LEE

(Type or Print)

RONALD WARD

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

November 15, 1968

9:02 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33

JOHNS HOPKINS HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 15, 1968

9:02 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX
Male7. RACE
White8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

26 YES ☒ NO ☐

9. DATE OF BIRTH

Apr. 18, 1948

10. AGE (In years
lost birthday)

20

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3808 Bonview Avenue

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William A. Ward

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Punch Press Opr. Westinghouse Co.

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Addie Daniels

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

216-52-8420

18. INFORMANT

ADDRESS

Wm. C. Ward, brother, 3808 Bonview Ave.

19. 485X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxiation, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Cerebral Anoxia and Bronchopneumonia

(A) IMMEDIATE CAUSE

~~TOXIC OVERDOSE OF HEROIN~~

(B) complicating overdose of heroin

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 15, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/18/68

24C. NAME of CEMETERY or CREMATORY

Lake View Mem. Park

24D. LOCATION (City, town, or county)

Randallstown, Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 19 1968

25B. NAME OF REGISTRAR

Robert E. Farber

25C. FUNERAL DIRECTOR

Schimunek Funeral Home Inc.

ADDRESS

3331 Brehms Lane

— *W. W. W.*

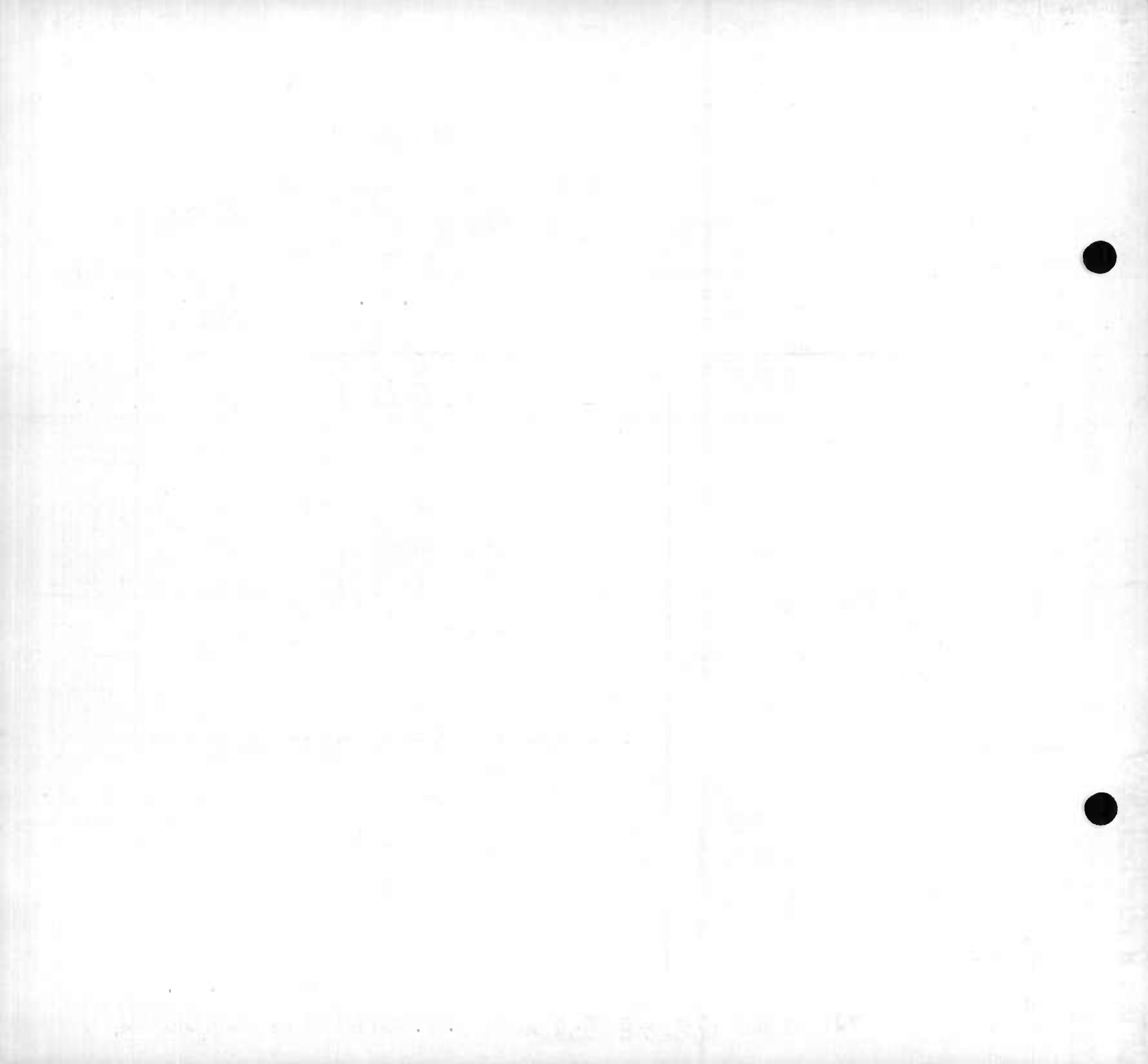
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11574 CERTIFICATE OF DEATH

REG. NO. 68-11574

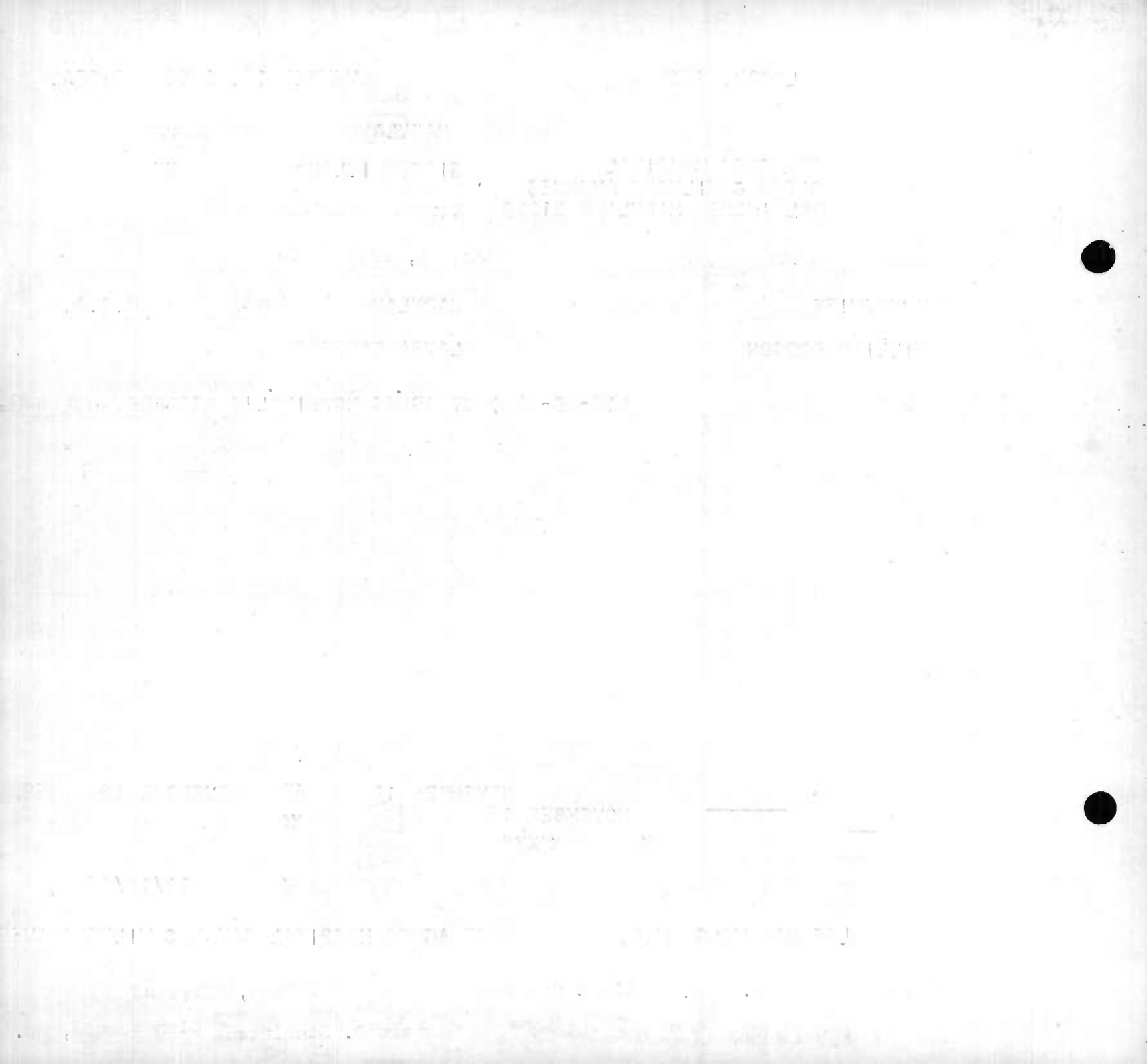
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GUY JORDAN		2. DATE AND HOUR OF DEATH 11-15-68 6¹²A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY Balto Co 53-00 C. CITY OR TOWN Reisterstown D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Calder Lane	
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-16-94	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Co.	
13. FATHER'S NAME John Jordan				14. MOTHER'S MAIDEN NAME Sarah Clark	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-07-9847		17. INFORMANT ADDRESS Mrs. Louise Jordan Reisterstown, Md.	
18. 593.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Uremia kidney failure DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 5-93 X II				chronic obstructive lung disease	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-9-68 to November 15 1968 , that (I) (we) last saw the deceased alive on Nov 15 1968 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel Greenwood MD				23B. DATE SIGNED 11-15-68	
23C. PHYSICIAN'S NAME (Type) DANIEL GREENWOOD				23D. ADDRESS SINAI HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/18/68		24C. NAME OF CEMETERY or CREMATORY St Lukes Cemetery	
24D. LOCATION Reisterstown, Md.		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS J. F. Eling & Sons Reisterstown, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

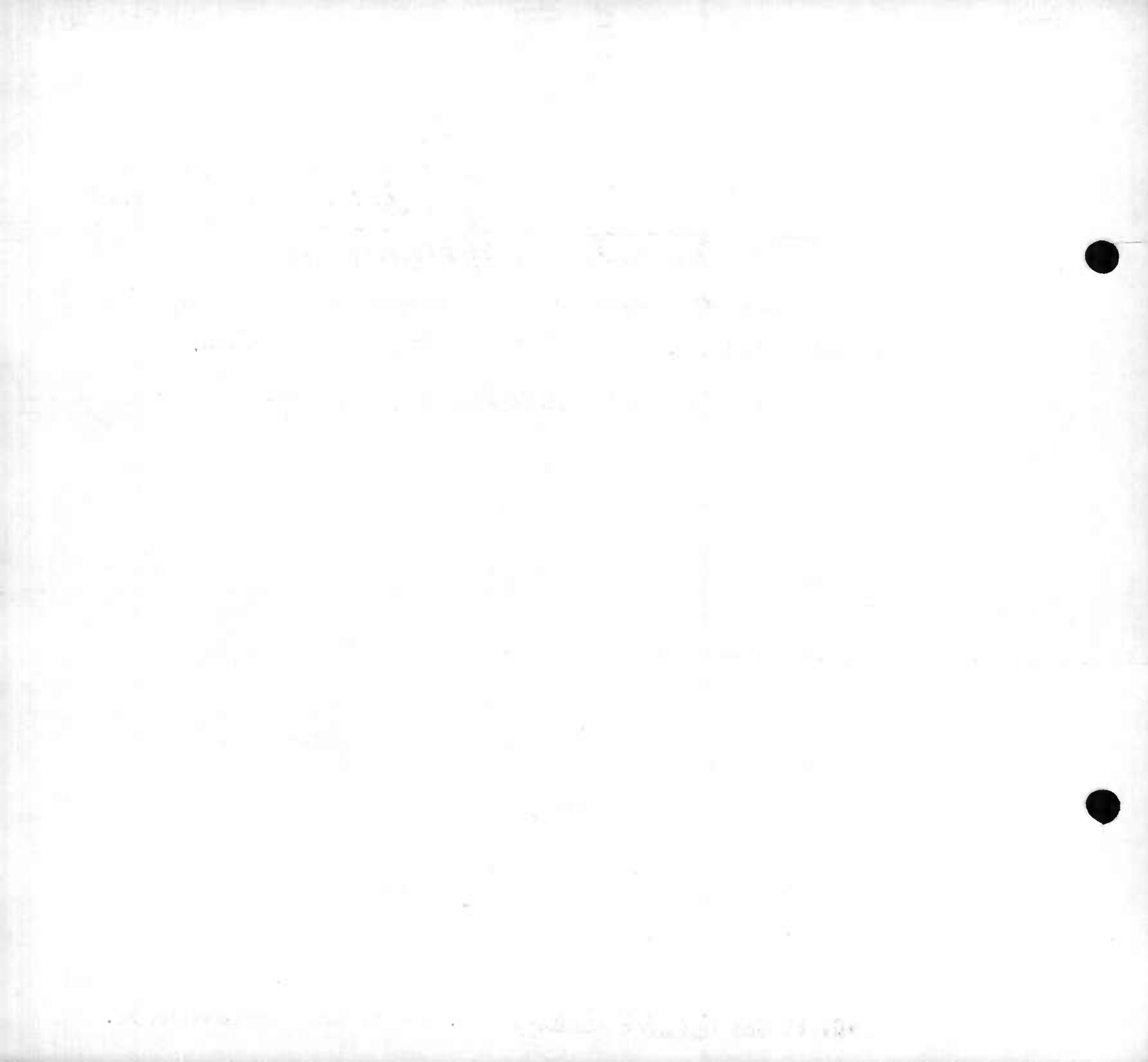
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11575
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		LUSBY, ETTA Mae		NOVEMBER 16, 1968 5:35A. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		A. STATE MARYLAND		
		B. COUNTY Anne Arundel 52-00		
		C. CITY OR TOWN GIBSON ISLAND		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER XXXXXX Aberfoyle Road		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1890	9. AGE (In years lost birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) MARYLAND (Olivet)	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM DODSON		14. MOTHER'S MAIDEN NAME LAURA SANDERS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO None		16. SOCIAL SECURITY NO. 216-05-8407		17. INFORMANT Mr. William E. Lusby (husband)
		ADDRESS ST AGNES HOSPITAL'S RECORDS Same as #13		
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Cardiac Arrest and Respiratory failure</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral vascular accident.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19. DATE OF OPERATION 331X		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>NOVEMBER 13</u> 19 <u>68</u> to <u>NOVEMBER 16</u> 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>NOVEMBER 16</u> 19 <u>68</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.				
23A. SIGNATURE <i>L. M. Wong</i>		23B. DATE SIGNED 11/16/68		
23C. PHYSICIAN'S NAME (Type) LEE MAN WONG, M.D.		23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVES		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov. 18/68	24C. NAME OF CEMETERY or CREMATORY Olivet Cemetery	24D. LOCATION (City, town, or county) (State) Olivet, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968	25B. NAME OF REGISTRAR <i>Robert E. Fairburn</i>	25C. FUNERAL DIRECTOR Richard V. Singleton		
		ADDRESS Glen Burnie, Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	68-11576
BIRTH NO. M.E. CASE NO.		68-11576		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Harry G. Nelson			Nov. 15, 1968 1:25 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
43 SOUTH BALTO. GENERAL Hosp.			Md. Montgomery Co. 65-00		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Silver Springs, Md.		
			D. STREET ADDRESS (If rural, give location)		
			3301 Briggs Chaney, Road		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Male	White	Married	Sept 19, 1927	41 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Foreman sand & gravel co			Virginia		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thomas Nelson			Elva Watson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
Yes W W II			23034 7676		Mary V. Nelson Silver Springs Md
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
420.9 I			Myocardial Infarction		
ANTECEDENT CAUSES			Arteriosclerotic Heart Disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
420.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 63 to 11/15 19 68, that (I) (we) last saw the deceased alive on Nov 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph E. Smith Jr.				11/16/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Joseph E. Smith Jr.				4140 Sandy Spring Rd. Burtonsville, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/20/68		Arlington National Cemetery	
				Arlington Arlington Virginia	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 19 1968		Robert E. Farkner		F. Gasch's Sons Hyattsville, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 10
BIRTH NO. 68-11577		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Elsie H. Sale		2. DATE AND HOUR OF DEATH 16 Nov 68 11 20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore city C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 10 Plateau Rd.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08-15-84	9. AGE (In years last birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Hoseman		
14. MOTHER'S MAIDEN NAME Martha Ballou		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 175-01-3310		17. INFORMANT ADDRESS Katharine Sub Dasht		
18. 579.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: septicemic UTI 3 weeks (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). AS CVD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 1/2 years		
19A. DATE OF OPERATION 2 Nov		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11-10 19 68 to 11-16 19 68 , that (I) (we) last saw the deceased alive on 11-16 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE BRIAN Block		23B. DATE SIGNED 16 NOV 68		23C. PHYSICIAN'S NAME (Type) BRIAN Block
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 11-17-68		24C. NAME OF CEMETERY or CREMATORY BELLE VERNON CEM.
24D. LOCATION (City, town, or county) (State) Belle Vernon - Penna		25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		
25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR ADDRESS Connelly, J. H. 300 Moore		

UNION MEMORIAL - 4024

Baltimore
to Boston 44

02-12-81

Walter Bolton

John H. H. H.

187-01-28

Kellam 2d

September 1871

92 100

Now

At

11-10

11-14-81

BRIAN BLOCK
for John H. H.

UNION NEW YORK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11578
BIRTH NO. <u>68-11578</u>		1. NAME OF DECEASED <u>DEEL, RICHARD CONSTANTINE</u>		
2. DATE AND HOUR OF DEATH <u>11.16.68</u>		3. PLACE IN <u>BALTIMORE, MARYLAND</u> , WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. DATE OF DEATH <u>8-09 A.M.</u>		
A. STATE <u>MARYLAND</u>		B. COUNTY <u>Harford</u>		
C. CITY OR TOWN <u>Aberdeen</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <u>423 WOODCREST DRIVE</u>		F. FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MARYLAND 38 HOSPITAL</u>		
G. SEX <u>M</u>		H. RACE <u>W</u>		I. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
J. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		K. DATE OF BIRTH <u>10.18.68</u>		L. AGE (In years lost birthday) <u>29</u>
M. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>m Infant</u>		N. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		O. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
P. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		Q. FATHER'S NAME <u>RICHARD DEEL</u>		
R. MOTHER'S MAIDEN NAME <u>Carole Hoskins</u>		S. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
T. SOCIAL SECURITY NO. <u>N/A</u>		U. INFORMANT <u>Carole Deel</u>		
V. ADDRESS <u>Aberdeen, Maryland 21001</u>		W. CAUSE OF DEATH		
X. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Y. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u>		
Z. ANTECEDENT CAUSES		AA. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>RESPIRATORY FAILURE</u>		
AB. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		AC. CONGENITAL HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF:		
AD. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		AE. CONGENITAL HEART DISEASE		
AF. DATE OF OPERATION <u>11.14.68</u>		AG. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CONGENITAL HEART DISEASE</u>		AH. AUTOPSY? (Yes or No) <u>No</u>
AI. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		AJ. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		AK. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
AL. TIME OF INJURY (Month) (Day) (Year) (Hour)		AM. INJURY OCCURRED		AN. HOW DID INJURY OCCUR?
AO. While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		AP. I certify that (I) (this hospital) attended the deceased from <u>10.25.1968</u> to <u>11.16.1968</u> , that (I) (we) last saw the deceased alive on <u>11.16.1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
AQ. SIGNATURE <u>Free family</u>		AR. DATE SIGNED <u>11.16.68</u>		AS. DATE SIGNED
AT. PHYSICIAN'S NAME (Type) <u>GARVEY</u>		AU. ADDRESS <u>UNIVERSITY HOSPITAL</u>		AV. DATE SIGNED
AW. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		AX. DATE <u>18 Nov. 68</u>		AY. NAME OF CEMETERY or CREMATORY <u>Bel Air Memorial Gardens</u>
AZ. LOCATION (City, town, or county) <u>Bel Air, (Harford)</u>		BA. DATE <u>NOV 19 1968</u>		
BB. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		BC. FUNERAL DIRECTOR <u>Tarring Funeral Home</u>		

UNIVERSITY OF MARYLAND
 HOSPITAL
 10-18-68
 H W

RICHARD DEER
 MARYLAND
 RESPIRATORY FAILURE

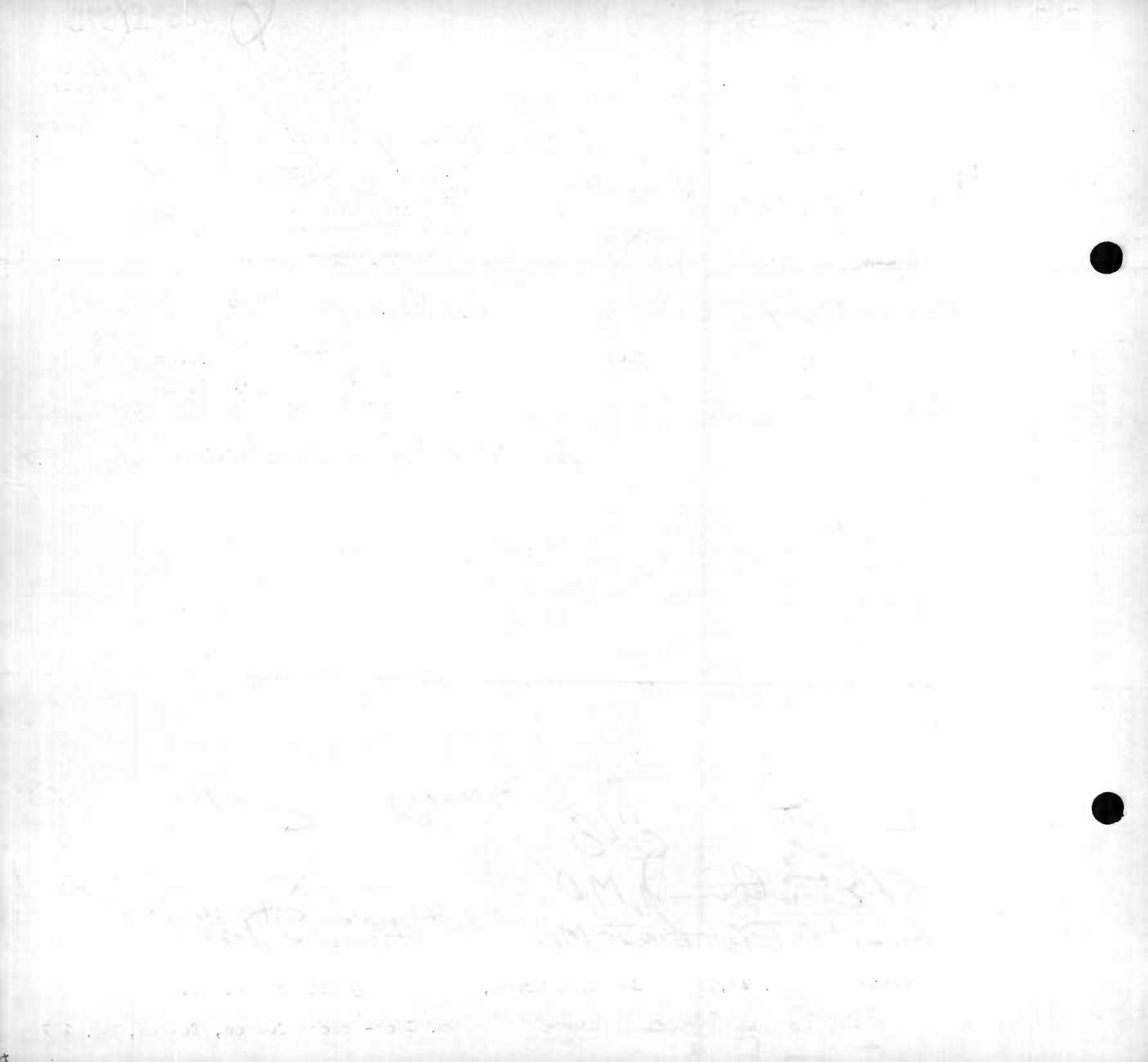
CONCENTRATED HEART DISEASE
 11-17-68 CONCENTRATED HEART DISEASE

UNIVERSITY HOSPITAL
 RESIDENT
 11-16-68
 10-22-68
 11-16-68
 CLEARVEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-640		68-11579		CERTIFICATE OF DEATH		REG. NO. 68-11579	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Carol Burl</i>			
2. DATE AND HOUR OF DEATH <i>11/18/68 4:40 a.m.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospital</i> 4940 EASTERN AVENUE #21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <i>8207 THORNTON ROAD #21204</i>							
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/20/43</i>		9. AGE (In years lost birthday) <i>25</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Garton</i>				14. MOTHER'S MAIDEN NAME <i>Marguerite Gengnagel</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>RECORDS BALTIMORE CITY HOSPITALS</i> 4940 EASTERN AVENUE #21224	
18. <i>2070 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Acute Blastic Leukemia</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>204.3 II</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Blastic Leukemia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7/23/68</i> 19 <i>68</i> to <i>11/18</i> 19 <i>68</i> . that (I) (we) last saw the deceased alive on <i>11/18</i> 19 <i>68</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Albert B. Einstein, M.D.</i>				23B. DATE SIGNED <i>11/18/68</i>			
23C. PHYSICIAN'S NAME (Type) <i>Albert B. Einstein, M.D.</i>				23D. ADDRESS <i>Baltimore City Hospital 21224 Baltimore, Md. 4940 Eastern Ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Nov. 21, 68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Chestnut Grove,</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 19 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Towson, Towson, Md. 21204</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 3 758-11580	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WILLIAM H. RICHARDSON		11-17-68M		9:20 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		MARYLAND		14-02	
5. SEX		6. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		1-10-26		82	
7. RACE		8. DATE OF BIRTH		9. AGE (In years last birthday)	
NEGRO		1-10-26		82	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Miner		Howardsville Va.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Willis Richardson		SALLIE Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		719-07-5068		Marry Bell 1708 Druid Hill Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		6 months	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		10 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		10 yrs	
421.1 II		Diabetes Mellitus			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
None		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
None					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that the (this hospital) attended the deceased from Jan 1957 to Nov 12 1968, that (I) we last saw the deceased alive on Nov 17 1968 and that in (my) an opinion death occurred on the date and hour and from the causes stated above. (I) we (did) not view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Richard W. Light		11/17/68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Richard W. Light		Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Shipped		11/21/68		Potomac	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 17 1968		Glen E. Fadden		Williams Funeral Home 3192 Schenck St	

Howardsville Va.
Johnson

Richardson

Minister

No

Mary Bell 1208 Dried Hill Ave

Captain (and others)

Ante (and others)

Richardson

222

None

None

18

18

18

18

X

Richard W. Light

Richard W. Light

Shipped 11/1/18

Richard W. Light

Richard W. Light

Dec 1944

Br/10

Track Driver

Yes

George Watkins

Ray's Robinson

21-11-44 Ray's Watkins 2003 Hollins St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11582

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11582

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Pearl M. Tyson		2. DATE AND HOUR OF DEATH Nov. 14, 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Baltimore B. COUNTY 8			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
00 506 E. Cold Spring Lane				Maryland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				506 E. Cold Spring Lane			
5. SEX Female	6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1908		9. AGE (In years last birthday) 59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Ridgeway S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James McGill				14. MOTHER'S MAIDEN NAME Mary Jones			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-14-4276		17. INFORMANT Arthaniel Louis Tyson 506 Coldspring Lane			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Hypertensive + Arteriosclerotic Heart Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH less than 1 year			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II				N/A			
19A. DATE OF OPERATION N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N/A	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) N/A		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		21C. WHERE DID INJURY OCCUR? N/A		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/14/68 to 11/14/68, that (I) (we) last saw the deceased alive on 11/14/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE U. Ray, Jr.				23B. DATE SIGNED 11/15/68		23C. PHYSICIAN'S NAME (Type) U. RAY, JR. M.D.	
23D. ADDRESS 2225 W North				23E. CITY, TOWN, OR COUNTY Baltimore Co. Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/19/68		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.		25D. ADDRESS	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11583

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELMER HOWELL

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 16, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 16, 1968

5:35 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

Yes ☒No ☐

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

Oct. 31, 1930

10. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1213 Edmondson Avenue

11. BIRTHPLACE (State or foreign country)

Roanoke Rapids, N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Martin

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Contractor

15. MOTHER'S MAIDEN NAME

Virginia Howell

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mr William Martin 2809 Clifton Ave.

19. 486X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Pneumonia with empyema

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxiation, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
(Partial)
Yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 17, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/23/68

24C. NAME of CEMETERY or CREMATORY

Family Lot

24D. LOCATION

(City, town, or county)

(State)

Roanoke Rapids, N.C.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

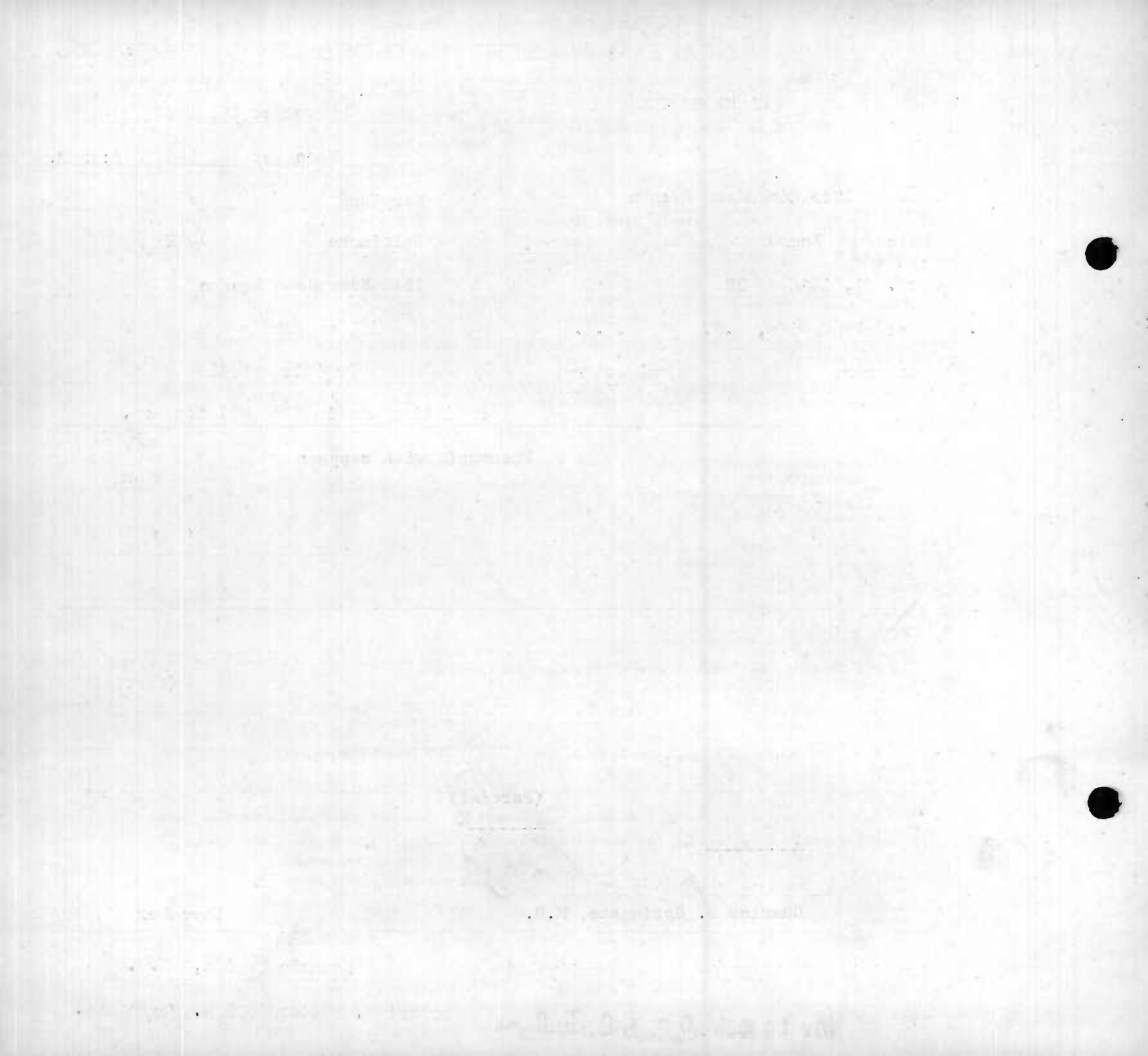
25C. FUNERAL DIRECTOR

ADDRESS

Herbert E. Nutter 3035 W. North Ave.

NOV 19 1968

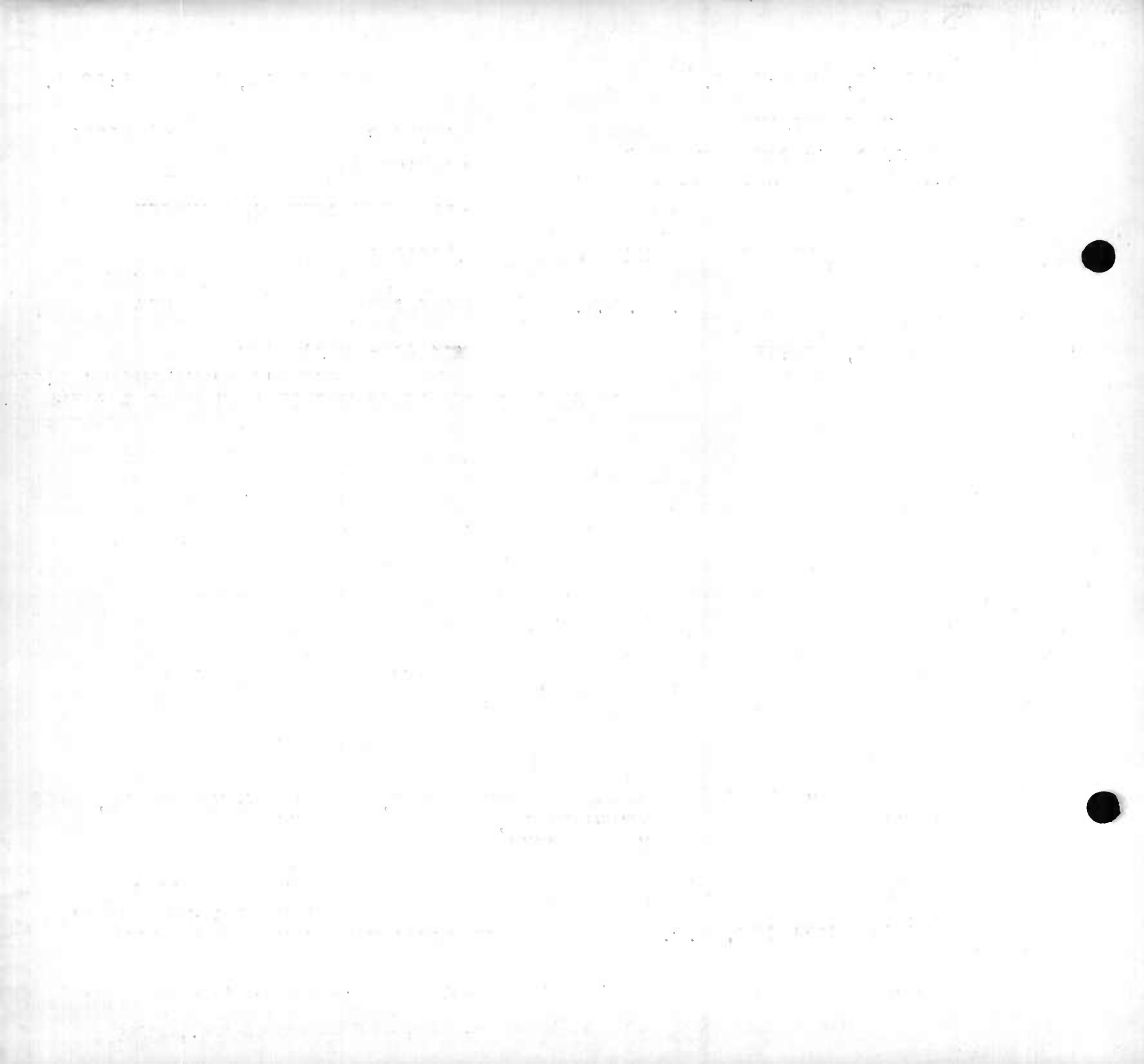
Robert E. Taylor



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11584</u>
5-553		68-11584		CERTIFICATE OF DEATH
BIRTH NO. <u>5-553</u>		1. NAME OF DECEASED <u>SIMONDS, HARRY C.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>ST AGNES HOSPITAL</u> <small>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small> <u>WILKENS AND CATON AVENUES</u>		2. DATE AND HOUR OF DEATH <u>NOVEMBER 19, 1968</u> <u>1:30</u> A. M.		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>20-05</u> <u>21223</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>04/01/83</u> 9. AGE (In years last birthday) <u>85</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R.R.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>SIMONDS, ROBERT</u>		14. MOTHER'S MAIDEN NAME <u>(SIMONDS) MARY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>705 07 4963</u>		
17. INFORMANT <u>RECORD'S BALTIMORE MD 21229</u>		18. ADDRESS <u>ST AGNES HOSPITAL WILKENS & CATON AVE</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>412.3 I</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>420.1 II</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>ARTERIOSCLEROTIC</u> DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIOVASCULAR DISEASE</u> (B) <u>DIFFUSE MYOCARDIAL ISCHEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GANGRENE LEFT FOOT</u>		
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____		
22. I certify that (X) (this hospital) attended the deceased from <u>NOVEMBER 8, 1968</u> to <u>NOVEMBER 19, 1968</u> , that (X) (we) last saw the deceased alive on <u>NOVEMBER 19, 1968</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.				
23A. SIGNATURE <u>Marino M. Cabiling M.D.</u>		23B. DATE SIGNED <u>11 19 68</u>		
23C. PHYSICIAN'S NAME (Type) <u>MARINO CABILING, M.D.</u>		23D. ADDRESS <u>WILKENS & CATON AVE'S</u> <u>ST AGNES HSP BALTIMORE MD 21229</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/22/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. STATE (State) _____		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 19 1968</u>		25B. NAME OF REGISTRAR <u>R. E. Jones</u>		25C. FUNERAL DIRECTOR <u>Witzke, 4101 Edmondson Ave., 21229</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 15-620		BALTIMORE CITY HEALTH DEPARTMENT 68-11585 CERTIFICATE OF DEATH		Registered No. 68-11585	
1. NAME OF DECEASED (Type or Print) <i>Edmonia E. Bowers</i>			2. DATE AND HOUR OF DEATH <i>11/17/68</i> <i>6:50 PM.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>5207 Overcrest Ave.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>12/24/91</i>	9. AGE (In years lost birthday) <i>76</i>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Poolesville, Maryland</i>	
13. FATHER'S NAME <i>William Lewis</i>			14. MOTHER'S MAIDEN NAME <i>Susanne Howe</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-30-5830</i>		17. INFORMANT <i>Mr. Harry Berry, 5207 Overcrest Ave. 21207</i>	
18. 44191 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>RP hemorrhage</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Ruptured atherosclerotic abdominal aneurysm hours</i>			INTERVAL BETWEEN ONSET AND DEATH		
19. 437X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Agustin del Campo MD</i>				23B. DATE SIGNED <i>Nov. 17 68</i>	
23C. PHYSICIAN'S NAME (Type) <i>AGUSTIN del CAMPO</i>				23D. ADDRESS <i>Bon Secours Baltimore Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/21/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 19 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>Witzke, 4101 Edmondson Ave. 21229</i>			

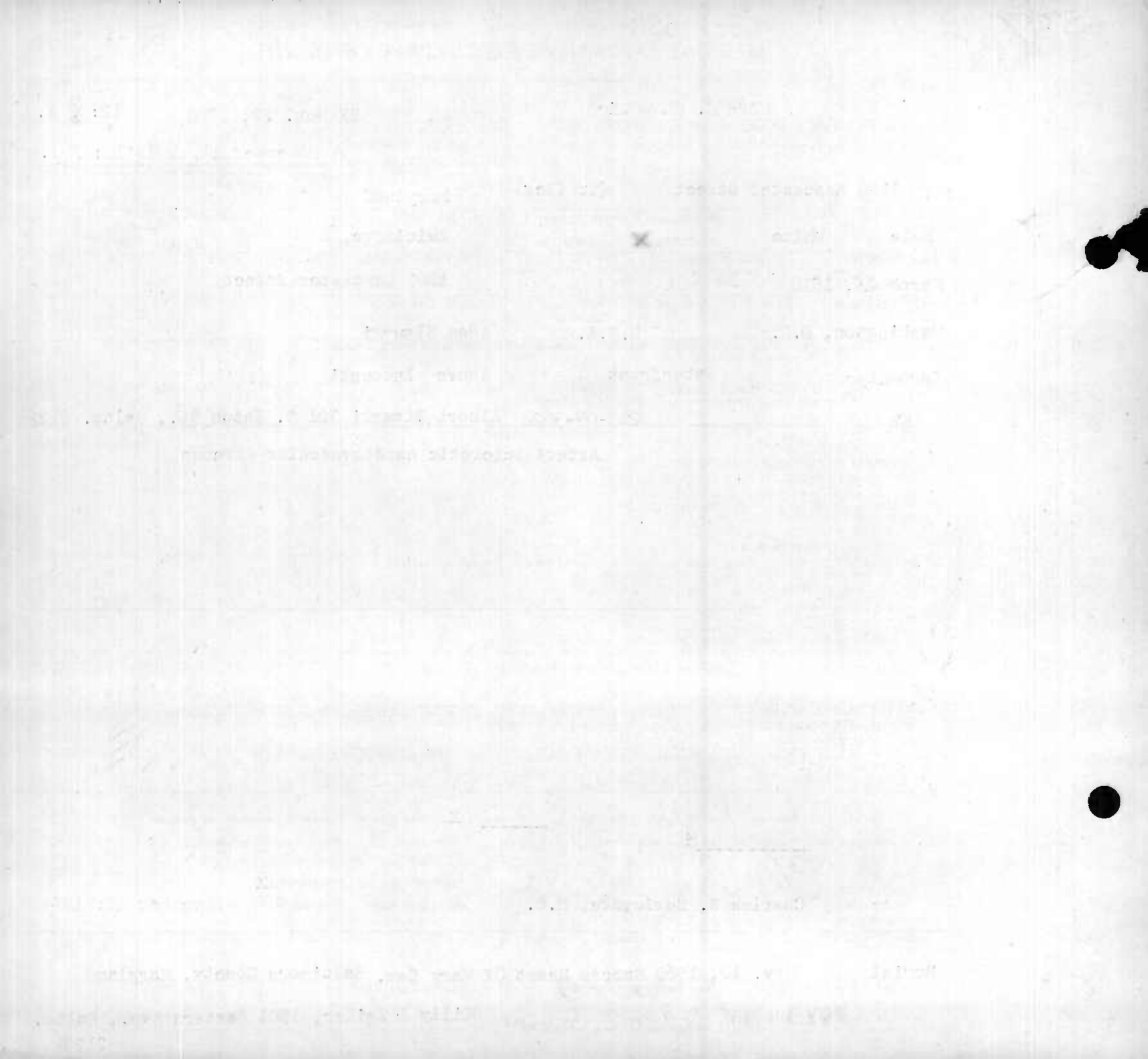
68-11586 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11586

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JOSEPH S. SLAWSKI		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> Nov. 12, 1968 Hour 12:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1200 Lancaster Street (Trailer)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 14, 1968 11:45 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH March 15, 1918		10. AGE (In years last birthday) 50 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		14B. KIND OF BUSINESS OR INDUSTRY Waterfront	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 213-09-3028	
13. FATHER'S NAME Adam Slawski		15. MOTHER'S MAIDEN NAME Agnes Lukowski	
18. INFORMANT Albert Slawski		ADDRESS 701 S. Eaton St., Balto, 21224	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 18, 1968	
24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Mary Cem.		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Juley	
25C. FUNERAL DIRECTOR Lilly & Zeiler, 1901 Eastern Ave., Balto.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11587 CERTIFICATE OF DEATH

REG. NO. 68-11587

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Harry Elmer WILLOUGHBY</u>		2. DATE AND HOUR OF DEATH <u>November 17, 1968</u> <u>10:45</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore City</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>U.S. Public Health Service Hospital</u> <u>Baltimore, Md. 21211</u>				C. CITY OR TOWN <u>BALTIMORE</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>25 Exeter Street</u> <u>3-02</u>	
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1909</u>	9. AGE (In years lost birthday) <u>59</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>massman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>merchant seaman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Franklin Willoughby</u>	
14. MOTHER'S MAIDEN NAME <u>Zorra Collison</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>214-14-1280</u>				17. INFORMANT <u>Hospital Records</u>	
ADDRESS					
18. <u>153701-571.0</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hepatitis</u> (B) <u>cirrhosis of liver</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>chronic alcoholism</u>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u> <u>years</u>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 3, 1968</u> to <u>November 17, 1968</u> , that (I) (we) lost saw the deceased alive on <u>November 17, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> DEGREE				23B. DATE SIGNED <u>November 17, 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>MIHALY BARTALOS, M.D.</u> DEGREE				23D. ADDRESS <u>U.S. Public Health Service Hospital, Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Nov. 20, 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Park Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 19 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins, MA</u>		25C. FUNERAL DIRECTOR <u>Lilly & Zeller, Inc. 1901 Eastern Ave.</u>	
ADDRESS <u>Baltimore, Md. 21231</u>					

DATE: 1963

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11588
BIRTH NO.		68-11588		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Cora Belle Gnagey			Nov. 15, 1968 11:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2938 ST. PAUL ST. & 30TH 00			A. STATE Md. Baltimore C 53-00		
			C. CITY OR TOWN Pikesville		
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			E. STREET AND NUMBER 103 Waldron Ave.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1880	9. AGE (In years lost birthday) 88 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY Own home			11. BIRTHPLACE (State or foreign country) Mt. Morris		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Oscar Allen			14. MOTHER'S MAIDEN NAME Ella Williams		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None			16. SOCIAL SECURITY NO. 215-52-7296		17. INFORMANT Pikesville 8, Md. Mrs. Willis W. Dexter, 103 Waldron Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary vessel disease (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertensive cardiac disease (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) X		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) X		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) X		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? X	
22. I certify that (I) (this hospital) attended the deceased from Nov 5 1968 to Nov 15 1968, that (I) (we) lost saw the deceased alive on 11/15 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Grace E. Jones, M.D.			23B. DATE SIGNED 11/17/68		23C. PHYSICIAN'S NAME (Type) Dr. Grace E. Jones
23D. ADDRESS 12 Walker Ave Balto 21208			23E. FUNERAL DIRECTOR Frank H. Newell, Pikesville 8, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 18, 1968		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville		24E. LOCATION Baltio. Md.		24F. LOCATION Pikesville	
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Frank H. Newell, Pikesville 8, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11589		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11589	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
GRACE W. COOK		November 17, 1968		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 KENSON NURSING HOME 2922 Arunah Avenue		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 437 Cummings Court			
5. SEX F.	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12-30-1882	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-16-2637		17. INFORMANT ADDRESS Mr. Edward Towson 501 W. Mosher St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Cardio-Vascular Disease Several years DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		MEDICAL CERTIFICATION			
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 3, 1968 to Nov. 17, 1968, that (I) (we) lost saw the deceased alive on Nov. 17, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank W. Ogden				23B. DATE SIGNED Nov. 19, 68	
23C. PHYSICIAN'S NAME (Type) FRANK W. OGDEN		23D. ADDRESS 2701 N. Calvert St - Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-20-68		24C. NAME of CEMETERY or CREMATORY Mount Auburn Cem.	
24D. LOCATION Baltimore, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. NOV 19 1968			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St.			

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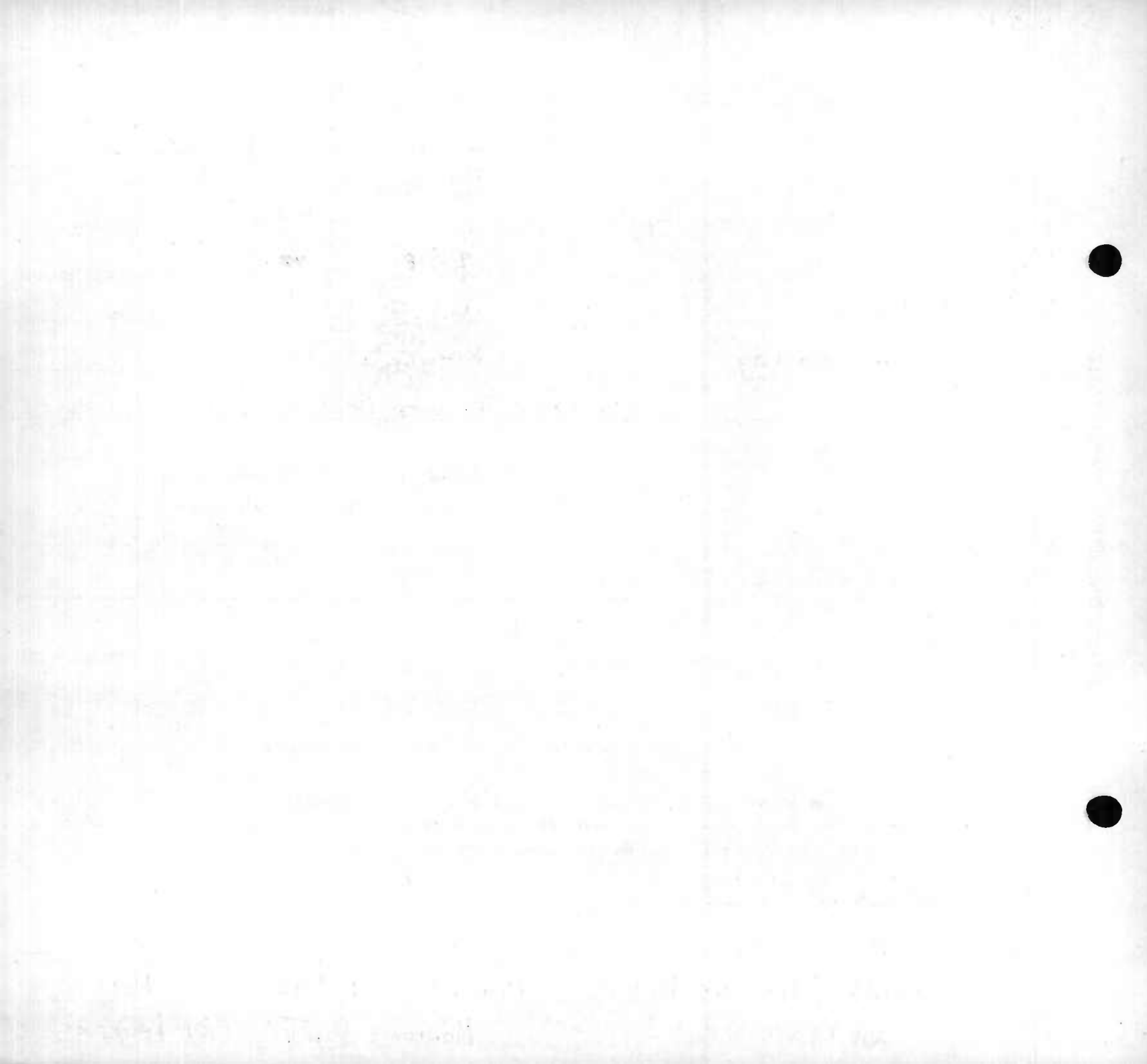
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11590 CERTIFICATE OF DEATH

REG. NO. 68-11590

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Martha Bridges</u>		2. DATE AND HOUR OF DEATH <u>11/18/68</u> <u>6⁰⁰</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>—</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAID</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		8. DATE OF BIRTH <u>9/5/96</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		9. AGE (In years last birthday) <u>72</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Moses Waddy</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Johnson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>219-16-2768</u>		17. INFORMANT <u>Theodore Bridges</u>		ADDRESS <u>600 Cherry Crest Rd.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Adenocarcinoma - primary site unknown</u>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Widespread metastatic</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Congestive Heart Failure</u>					
21A. DATE OF OPERATION <u>0</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (the) (this hospital) attended the deceased from <u>11-6</u> 19 <u>68</u> to <u>11-18</u> 19 <u>68</u> , that (we) lost saw the deceased alive on <u>11-18</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley R. Weimer, M.D.</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Stanley R. Weimer, M.D.</u>		23D. ADDRESS <u>South Baltimore General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-20-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem PK.</u>	
24D. LOCATION (City, town, or County) <u>Balto.</u>		24E. STATE <u>MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 19 1968</u>	
25B. NAME OF REGISTRAR <u>Robert E. Feltz</u>		25C. FUNERAL DIRECTOR <u>MORTON & DYETT</u>		ADDRESS <u>1701 LAURENS</u>	

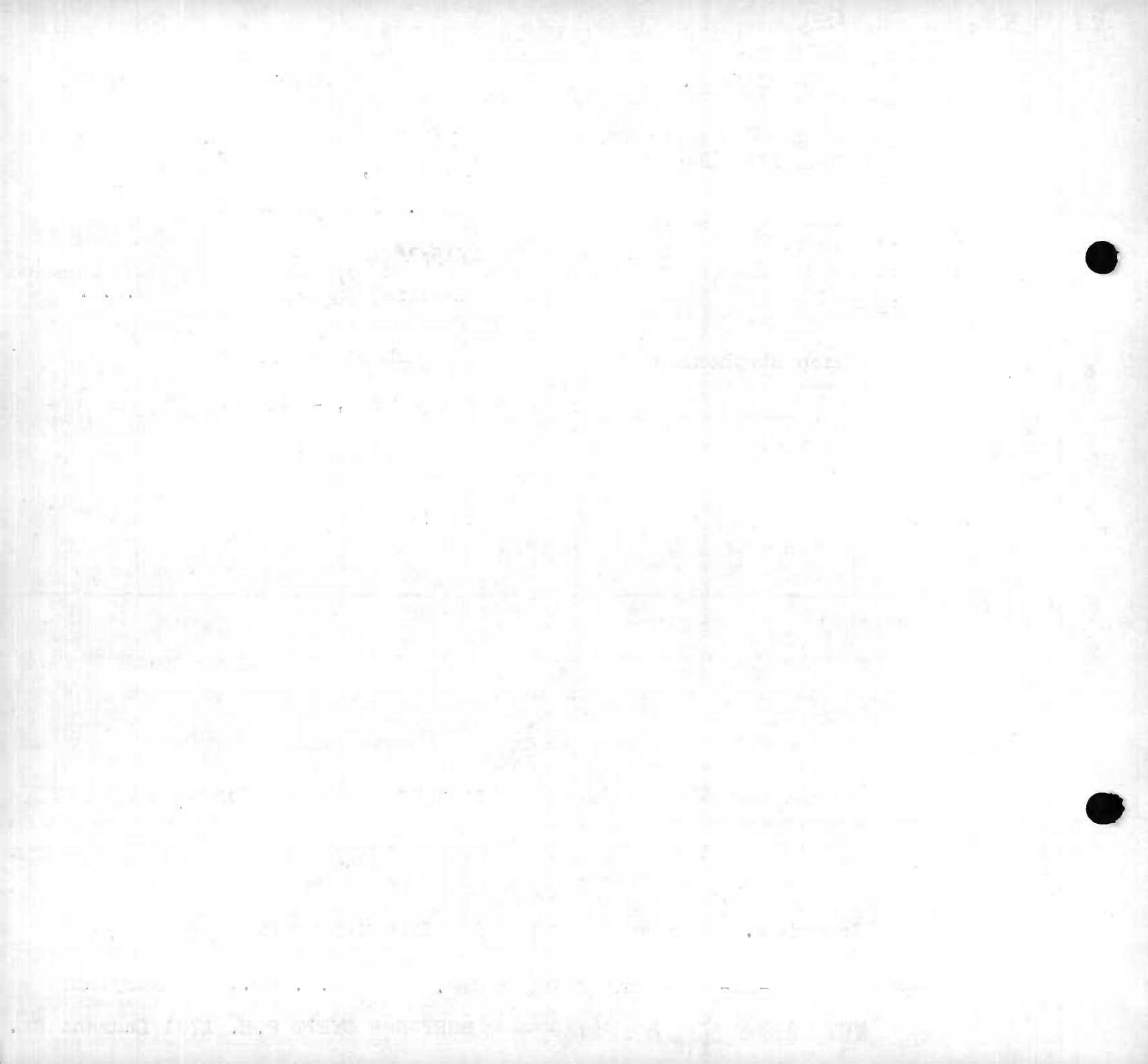


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11591 CERTIFICATE OF DEATH

REG. NO. 68-11591

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Melone, Allie B.		2. DATE AND HOUR OF DEATH 11/16/68 4:55p M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		C. CITY OR TOWN Baltimore,		E. STREET AND NUMBER 936 W. Franklin Street	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/15/1896	9. AGE (In years lost birth day) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia, Boykins	
13. FATHER'S NAME Simon Stephenson		14. MOTHER'S MAIDEN NAME Roberta Sykes		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lacey White, -neighbor	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Congestive Heart Failure Secondary to HCVD Uremia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. 443X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/28/68 19 to 11/16/68 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gregorio S. Tengco MD		23B. DATE SIGNED 11/18/68		23C. PHYSICIAN'S NAME (Type) Gregorio S. Tengco MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-21-68		24C. NAME of CEMETERY or CREMATORY Mount Calvary Cem.	
24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland		24E. FUNERAL DIRECTOR MORTON & DYETT F.H.		24F. ADDRESS 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-11592	
BIRTH NO. 68-11592		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GRACE CAMPBELL TODD		2. DATE AND HOUR OF DEATH November 15, 1968 11:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 00		(If not in hospital or institution, give street address or location) 913 N. Carey Street		D. STREET ADDRESS (If rural, give location) 913 N. Carey Street	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-17-1901	9. AGE (In years lost birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME UNKNOWN		
14. MOTHER'S MAIDEN NAME UNKNOWN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Osabell Hawkins		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 153.8 Metastatic Carcinoma of Liver 153.8 II Carcinoma of Colon			INTERVAL BETWEEN ONSET AND DEATH 12 months 21 months		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 1, 1968 to November 15, 1968 , that (I) (we) lost saw the deceased alive on November 14, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel R. Owings, Jr.				23B. DATE SIGNED 11-15-68	
23C. PHYSICIAN'S NAME (Type) SAMUEL R. OWINGS, JR.				23D. ADDRESS 909-11 N. Carey Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-18-68		24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968			
25B. NAME OF REGISTRAR Robert E. Fairbairn		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurans St.			

Secretary of Labor
Washington, D.C.

October 14, 1939

PCP-11-1 (10-1-39)

James R. Brown
Samuel R. Brown, Jr.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11593

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ARTHUR (James) WILLIAMS

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 16, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 16, 1968

5:20 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

7. RACE

8. MARRIED ☒ NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Male

Negro

WIDOWED ☐DIVORCED ☐

Baltimore

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

8-27-1898

70

E. STREET AND NUMBER

2542 Mosher Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Arbutus, Maryland

U.S.A.

CHARLES WILLIAMS

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Retired

ELIZABETH GREEN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

No.

217-09-4682A

Mrs. Nellie Williams

2542 W. Mosher

19. 4124

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 17, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

11-20-68

Arbutus Mem. Park

Arbutus,

Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 19 1968

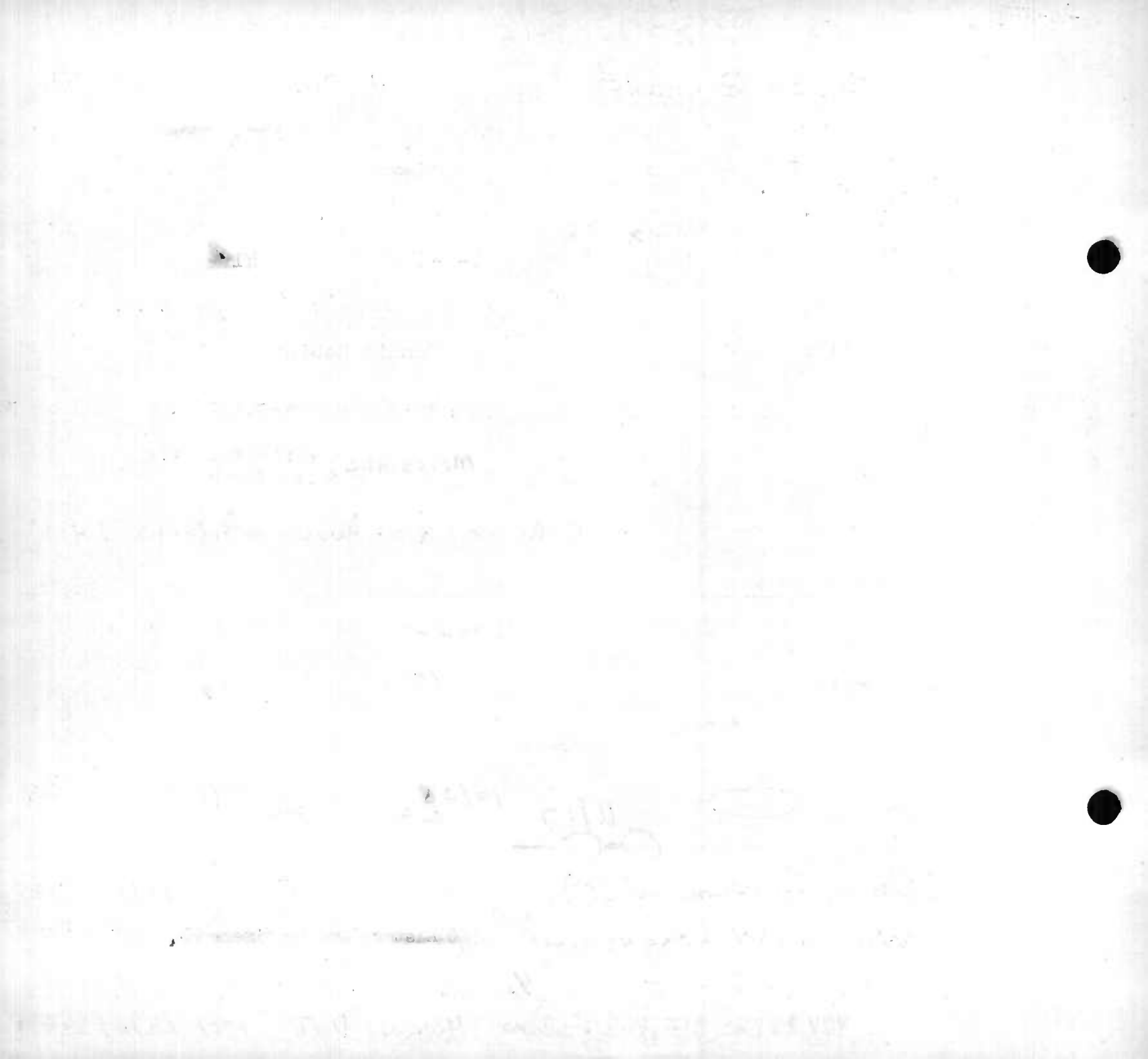
Robert E. Farkner

MORTON & DYETT F.H. 1701 Laurens St.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

52-91-57JD

G-456 68-11594				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11594	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) SLIZA GILMORE		2. DATE AND HOUR OF DEATH 11/17/68 4³⁰ P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern ave. Baltimore Md. #21224				C. CITY OR TOWN Baltimore		E. STREET AND NUMBER 2904 Wynham Rd.	
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-5-1927	9. AGE (In years lost birthday) 41	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Edwards, NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alex Miner				14. MOTHER'S MAIDEN NAME Connie Robinson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT BOH: Records 4940 Eastern Avenue Baltimore Md		ADDRESS #21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 14499 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 144X II				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTATIC UNDIFFERENTIATED CARCINOMA (B) CARCINOMA OF ALVEOLAR R. LUNG (C) NONE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 2 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 144X II							
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/26 19 68 to 11/17 19 68 , that (I) (we) last saw the deceased alive on 11/17 19 68 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Wm. W. Lukensmeyer MD				23B. DATE SIGNED 11/17/68			
23C. PHYSICIAN'S NAME (Type) WILLIAM W. LUKENSMEYER				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave Baltimore Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-27-68		24C. NAME of CEMETERY or CREMATORY BALTO. NATIONAL		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR MORTON & DGETT		ADDRESS 1701 LAURENS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452 68-11595		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 68-11595	
1. NAME OF DECEASED (Type or Print) MARY E. WILLIAMS			2. DATE AND HOUR OF DEATH November 16, 1968		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 817 N. Fremont Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland, Baltimore City C. CITY OR TOWN D. INSIDE CITY LIMITS Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 817 N. Fremont Avenue		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-31-1892	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Thumberland Co., Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALFRED QUINNEY		14. MOTHER'S MAIDEN NAME UNK.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-18-0572A		17. INFORMANT Mrs. Trent	
				ADDRESS 1722 Presbury	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.21X-174X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes (C) Coronary Artery Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs 2 yrs		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 473X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 16 1968 to Nov 19 1968 , that (I) (we) last saw the deceased alive on 5 Nov 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Simon H. Carter, Jr.				23B. DATE SIGNED 16 Nov 68	
23C. PHYSICIAN'S NAME (Type) Simon H. Carter, Jr.				23D. ADDRESS 4215 Park Hgths. Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-19-68		24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT.			
25A. NAME OF REGISTRAR Robert E. Jenkins		25B. FUNERAL DIRECTOR MORTON & DYETT F.H.		25C. ADDRESS 1701 Laurens St.	

Apprentice Card

Sum -
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Sum

Sum of Card

L-516

68-11596 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11596

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES LAMBERT SR.

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

11

14

68

6:05 p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

Mercy Hospital D.O.A.

3. DATE
PRONOUNCED DEAD

November 14, 1968 6:05 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

7/19/1917

10. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

506-510 Forrest St.

11. BIRTHPLACE (State or foreign country)

Grafton, W. Va.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Lambert

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

INEZ

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, not unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mr. Charles Lambert, Jr. 704 S. Tagley St.

19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH(A) IMMEDIATE CAUSE Carbon monoxide poisoning
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

506-510 Forrest St. 3rd floor apt. rear

22D. TIME
OF INJURY
(APPROX.)

11 14 68 4:49p

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Conflagration

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 15, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/19/68

24C. NAME of CEMETERY or CREMATORY

Oaklawn Cem

24D. LOCATION

(City, town, or county)

(State)

Balto. Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

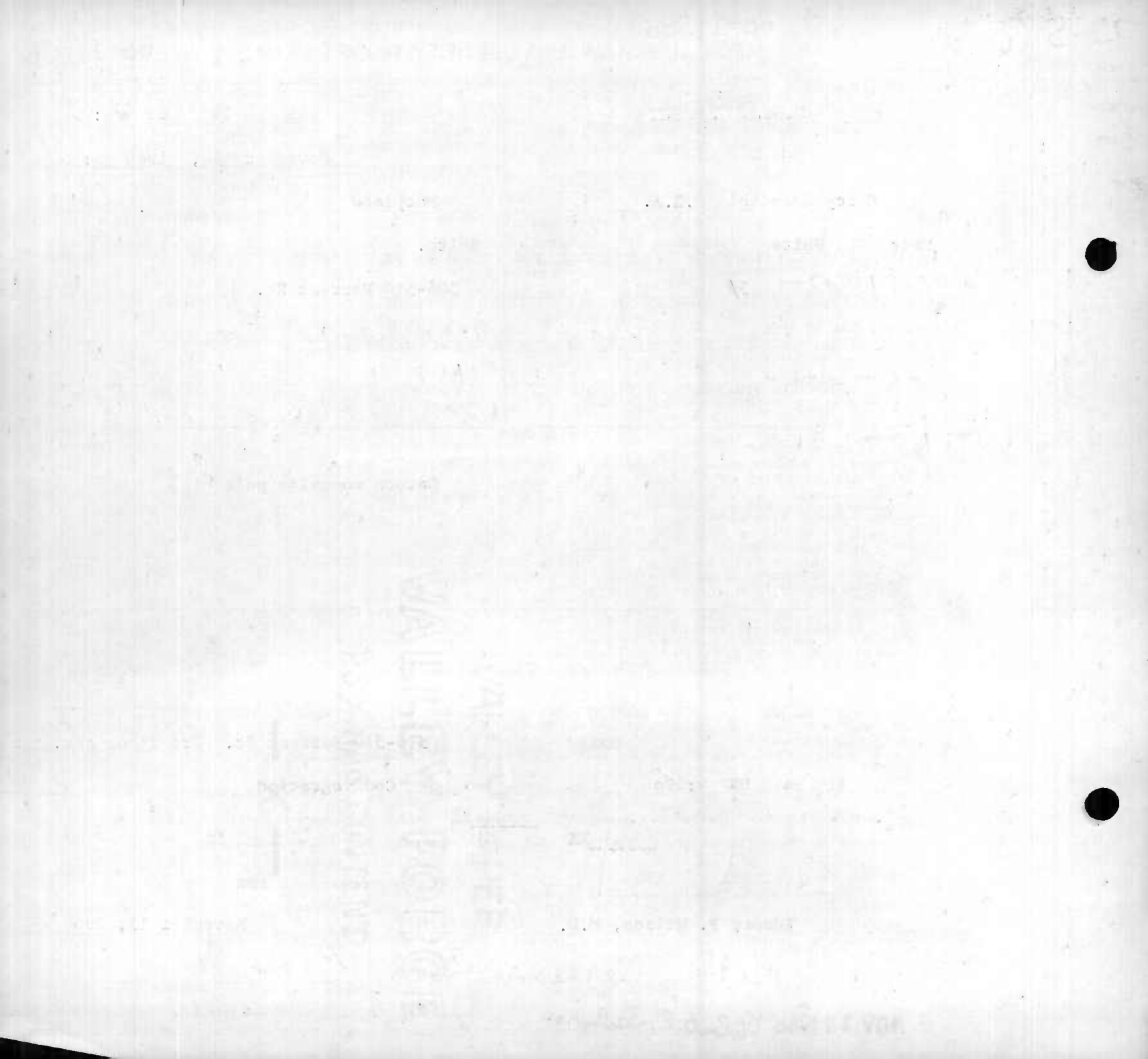
ADDRESS

NOV 19 1968

Robert E. Janney

J. N. Janney

263 S. Conkling Street



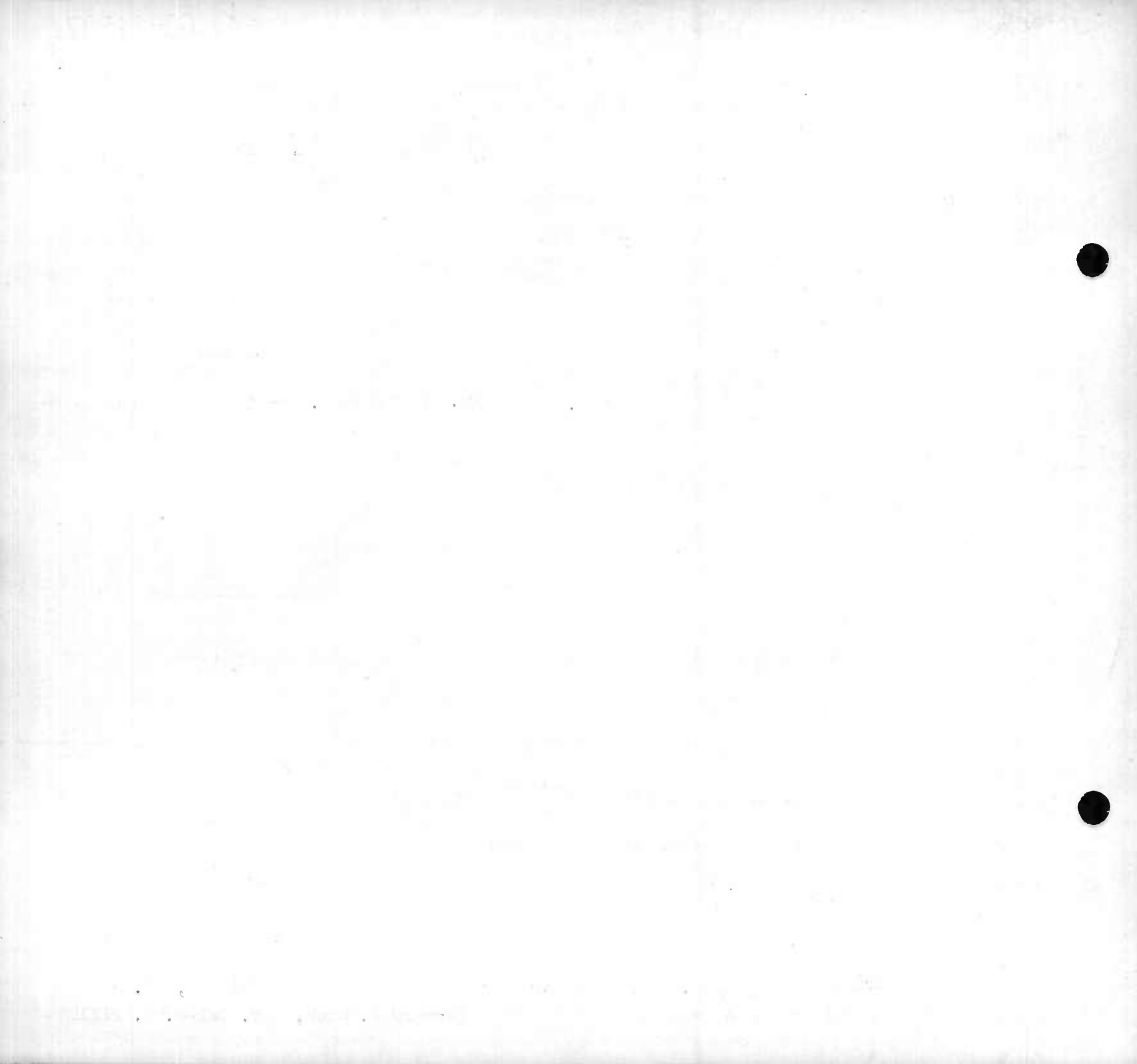
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11597 CERTIFICATE OF DEATH

REG. NO. 68-11597

BIRTH NO.		1. NAME OF DECEASED (Type or Print) EUGENIA R. JOHLITZ (Barber)		2. DATE AND HOUR OF DEATH 11/18/68 10²⁵ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION: UNION MEMORIAL HOSPITAL ADDRESS OR LOCATION: 33RD & CALVERT STS BALT. MD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD B. COUNTY: USA C. CITY OR TOWN: BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER: 1305 STONEWOOD RD	
5. SEX: FEMALE	6. RACE: CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH: 3/6/92	9. AGE (In years last birthday): 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): MD.	
13. FATHER'S NAME: ? Henry				14. MOTHER'S MAIDEN NAME: Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No		16. SOCIAL SECURITY NO.: Unk.		17. INFORMANT: Mr. Frederick A. Johlitz (Sa mo)	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 4/10/9 I myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Anteriosclerotic Cardiovascular Disease OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): 420.1 II T. P.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION: 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No): YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.): (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/18 19 68 to 11/18 19 68 , that (I) (we) last saw the deceased alive on 11/18 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE: Donald M. Legum M.D.				23B. DATE SIGNED: 11/18/68	
23C. PHYSICIAN'S NAME (Type): Donald M. Legum M.D.				23D. ADDRESS: Union Memorial Hospital - Balt. MD	
24A. BURIAL CREMATION, REMOVAL (Specify): Burial		24B. DATE: 11/21/68		24C. NAME OF CEMETERY or CREMATORY: Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) (State): Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.: NOV 19 1968		25B. NAME OF REGISTRAR: John E. Barber, MD		25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214	



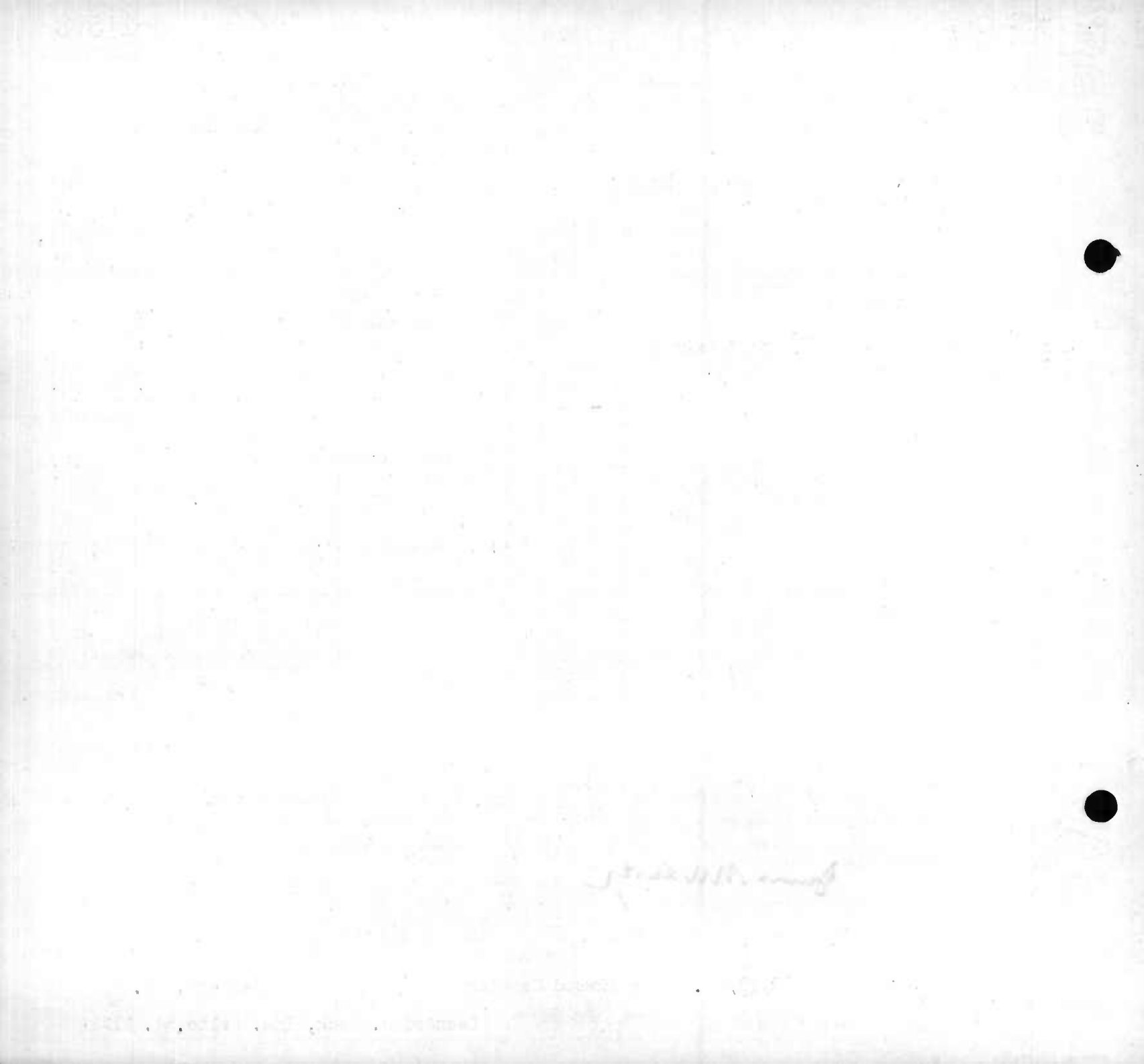
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68-11598 CERTIFICATE OF DEATH

REG. NO. 68-11598

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Vera Marie Wells		2. DATE AND HOUR OF DEATH Nov. 18, 1968 9 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		5. CITY OR TOWN Fork	
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Pk. Drive		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER Upland Road (Box 88)		6. DATE OF BIRTH 12/17/29		9. AGE (In years last birthday) 38	
S. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Wilbur Lehnhoff		14. MOTHER'S MAIDEN NAME Marie Polk		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 215-28-3879		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) Acute leukemia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months	
204.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 29 19 68 to Nov. 18 19 68, that (I) (we) last saw the deceased alive on Nov. 18 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James M. Weaver		23B. DATE SIGNED 11/18/68		23C. PHYSICIAN'S NAME (Type) James M. Weaver, Medical Director	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/21/68		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. ...	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11599 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH REG. NO. 68-11599

BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDMONDS, CHARLES W.		2. DATE AND HOUR OF DEATH 11/18/68 4:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		5. SEX Male 6. RACE W	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 614 HASTINGS Rd.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/4/01 9. AGE (In years last birthday) 67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME CHARLES G EDMONDS		14. MOTHER'S MAIDEN NAME MARGARET SCHAFER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS WILLIAM EDMONDS 3704 ELLERSLIE AVE BALTO MD	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction.		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. DATE OF OPERATION 11/16/68 11		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/16/68 19 68 to 11/18 19 68 , that (I) we last saw the deceased alive on 11/18 19 68 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.					
23A. SIGNATURE Charles S. Brown		23B. DATE SIGNED 11/18/68		23C. PHYSICIAN'S NAME (Type) Charles S. Brown	
23D. ADDRESS Union Memorial Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 11/21/68	
24C. NAME OF CEMETERY or CREMATORY Lorraine Mausoleum		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968	
25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25D. ADDRESS	

Miss Thomas (Hof)

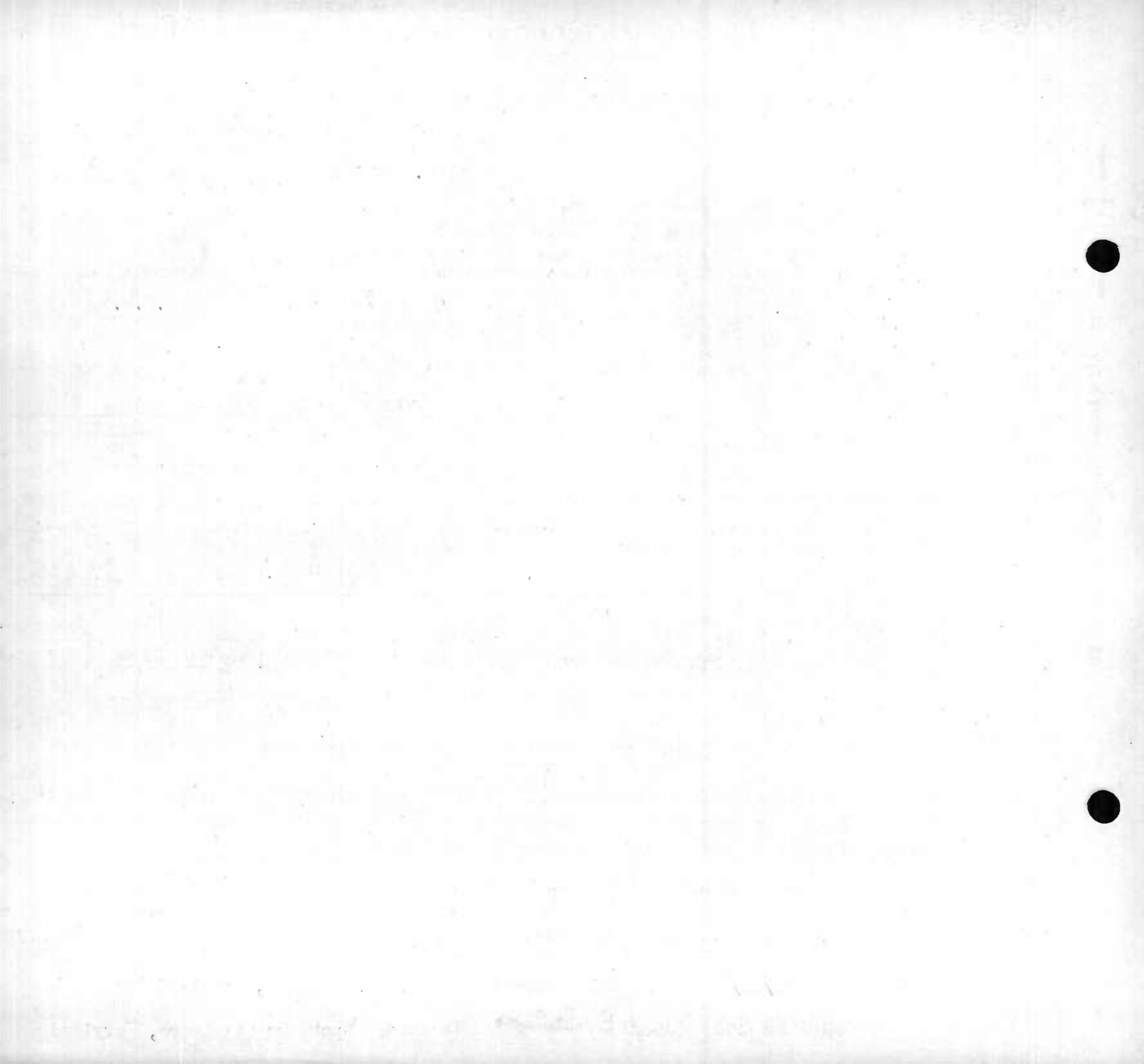
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11600

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11600

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LINARDI Anna		2. DATE AND HOUR OF DEATH 11/18/68 12:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 4310 Addison Lane Baltimore 21206		
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital			C. CITY OR TOWN Balto. City D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER Same as above					
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/1/1905	9. AGE (In years last birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Michael Vonditchi		14. MOTHER'S MAIDEN NAME Mary Feruneri	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT deceased Mr John Linardi	
18. 410.014250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction 2 days		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive C-V disease 5 years			
		(B) DUE TO, OR AS A CONSEQUENCE OF: Acute pulmonary disease 2 days			
		(C) Diabetes mellitus 10 yrs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/18 19 68 to 11/18 19 68 , that (I) (we) last saw the deceased alive on 11/18 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sang Yoon Rhim, M.D.				23B. DATE SIGNED 11/18/68	
23C. PHYSICIAN'S NAME (Type) SANG YOON RHIM		23D. ADDRESS South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/68		24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11601	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 68-22322 68-11601 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Baby Girl Hoeck			2. DATE AND HOUR OF DEATH 11-14-68 2:50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital 37 Mercy Hospital.			A. STATE Maryland B. COUNTY Baltimore Co C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8104 North Boundary Road		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-68	9. AGE (In years last birthday) 8	If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. 8 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Edwin Bennett Hoeck Jr.		14. MOTHER'S MAIDEN NAME C. Bennetta Knight	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Dundalk, Md. Mr. Edwin B. Hoeck Jr. 8104 N. Boundary Rd.	
18. 776.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Immaturity (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hyaline membrane disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 773.5 II			CAUSE OF DEATH Immaturity (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hyaline membrane disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes done	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 14 1968 to Nov 14 1968 , that (I) (we) last saw the deceased alive on Nov 14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S.K. Shin, M.D.				23B. DATE SIGNED 11/14/68	
23C. PHYSICIAN'S NAME (Type) S.K. SHIN, M.D.				23D. ADDRESS Mercy Hosp., Inc.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/16/68		24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Jesus	
24D. LOCATION (City, town, or county) Baltimore, Md.		(State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.	

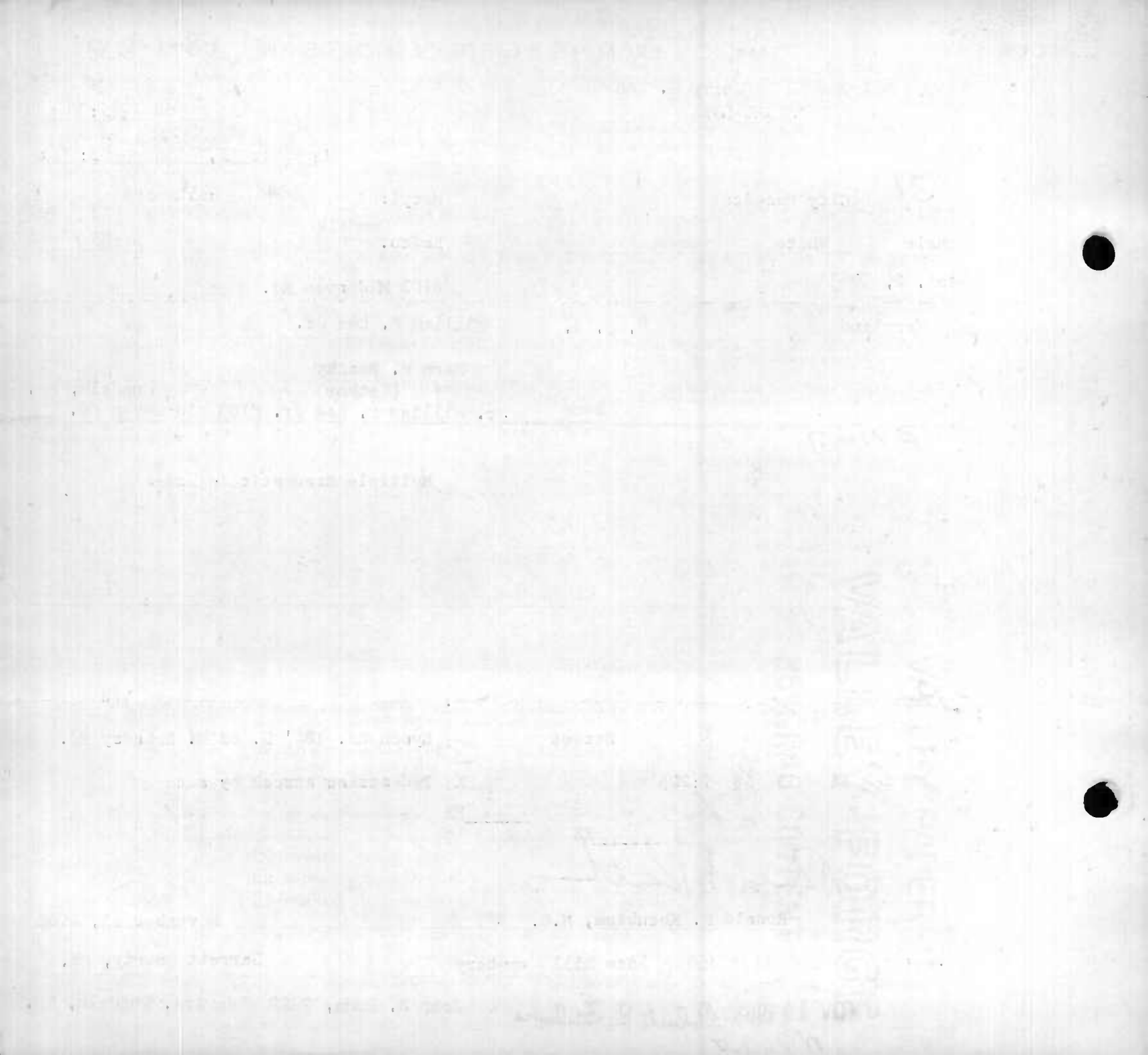
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 63-27252

68-11602

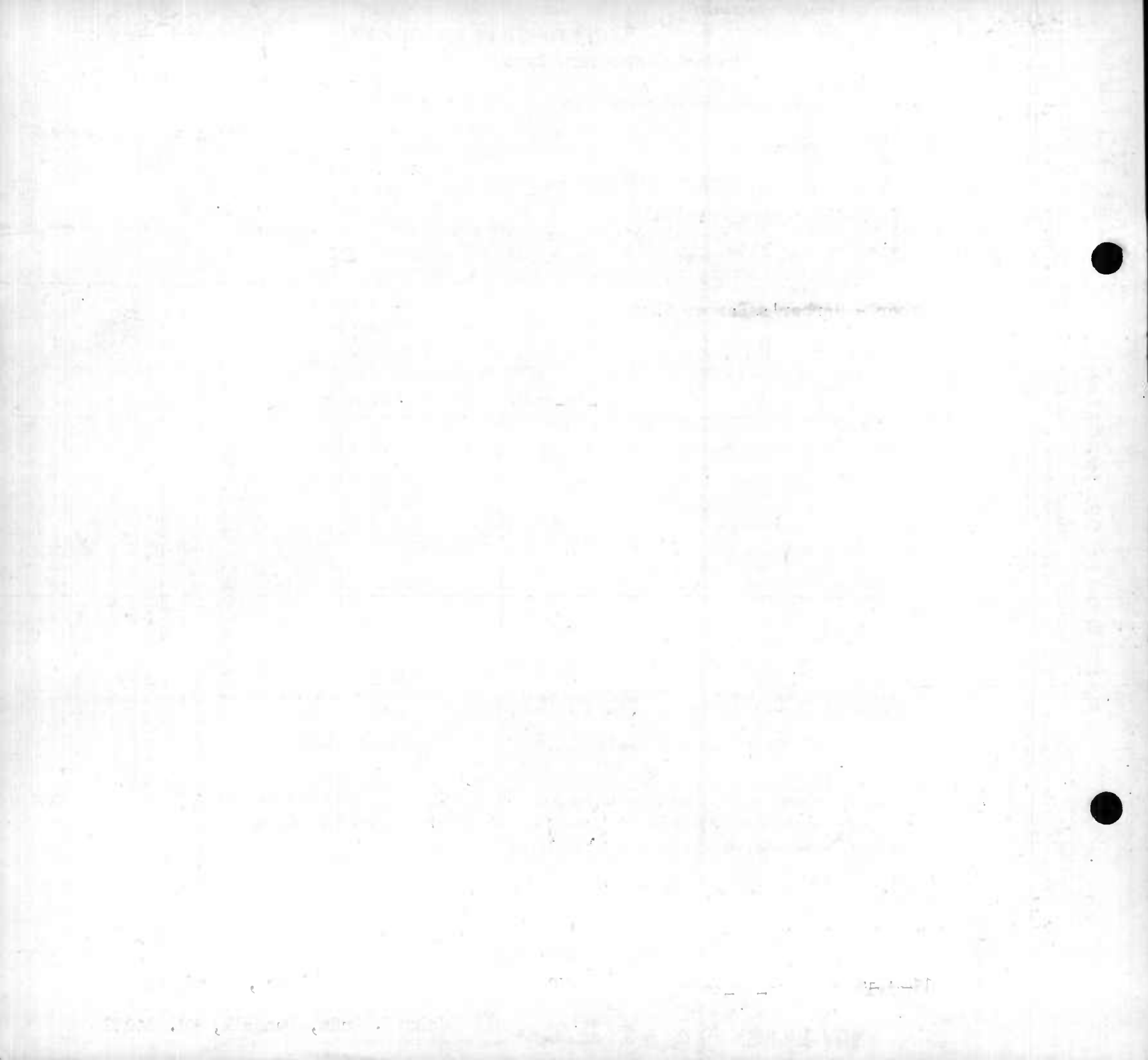
1. NAME OF DECEASED (Type or Print) Jerry W. Lee JERRY LEE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 15 68 5:00 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 City Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour November 15, 1968 5:00 a.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Dundalk Balto.	
9. DATE OF BIRTH Oct. 2, 1963		10. AGE (In years lost birthday) 5	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT (Father) Mr. William P. Lee Jr.		ADDRESS Dundalk, Md.	
19. E814.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple traumatic injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. E812.4 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
21. E812.4 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Lynch Rd. 184' N. of N. Boundary Rd.		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 11 13 68 7:22p	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by auto	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 15, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/18/68	
24C. NAME OF CEMETERY or CREMATORY Rose Hill Cemetery		24D. LOCATION (City, town, or county) (State) Garrett County, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11603
BIRTH NO. 68-11603		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) FREDERICK ELWOOD		2. DATE AND HOUR OF DEATH 11-16-68 7:57 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE HOSPITAL Franklin Square Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN Port Howard D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 20 BLANK AVENUE		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-29-68 9. AGE (In years last birthday) 60 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber - Gerber's Barber Shop		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES ELWOOD		
14. MOTHER'S MAIDEN NAME BECCY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 051-12-5250		17. INFORMANT ADDRESS UTAI RUANGWIT, M.D. FRANKLIN SQUARE HO.		
18. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Relat Pneumonia, lower lobe.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Portal cirrhosis - fatty metamorphosis		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 581.0 II		Atherosclerosis & myocardial hypertrophy		
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Aprox.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11-14-1968 to 11-16-1968 , that (I) (we) last saw the deceased alive on 11-16-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Utai Ruangwit, M.D.		23B. DATE SIGNED 11-16-68		23C. PHYSICIAN'S NAME (Type) UTAI RUANGWIT, M.D.
23D. ADDRESS FRANKLIN SQUARE HOSP. BALTO, M.D.		24. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 11-20-1968		24C. NAME OF CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, Dundalk, Md. 21222



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11604 CERTIFICATE OF DEATH


REG. NO. 68-11604

BIRTH NO.		1. NAME OF DECEASED (Type in Print) Mr. BURLEY HOYLE Burley Hoyle		2. DATE AND HOUR OF DEATH 11-17-68 9:05A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL 100 N. BROADWAY BALTIMORE - 21231				C. CITY OR TOWN EDGEWATER D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 3014 Sparrows Point Road (21219)					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-98	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETD BETH. STEEL		10B. KIND OF BUSINESS OR INDUSTRY BETH. STEEL		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME JOHN. A. HOYLE			14. MOTHER'S MAIDEN NAME Harriett		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. 216 10 1298		17. INFORMANT V. LANGADHARAN. M.D ADDRESS 100 N BROADWAY BALTO 21231	
18. 185X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 177X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MASSIVE GASTRO INTESTINAL HAEMORRHAGE.				HOURS.	
(B) CARCINOMA PROSTATE WITH SECONDARIES IN LIVER DUE TO, OR AS A CONSEQUENCE OF: OBSTRUCTIVE JAUNDICE				Weeks.	
(C) HEPATIC COMA				Weeks.	
MALNUTRITION, ELECTROLYTE IMBALANCE. CACHEXIA.				Weeks.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 0	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 0		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 0	
22. I certify that (I) (this hospital) attended the deceased from 11-8-1968 to 11-17-1968 , that (I) (we) lost saw the deceased alive on 11-17-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. C. VENERACION				23B. DATE SIGNED 11-17-68	
23C. PHYSICIAN'S NAME (Type) B. C. VENERACION				23D. ADDRESS Church Home & Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-20-1968		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park	
24D. LOCATION (City, town, or county) (State) Dorsey, Maryland					
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR John J. Duda, Dundalk, Md. 21222	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

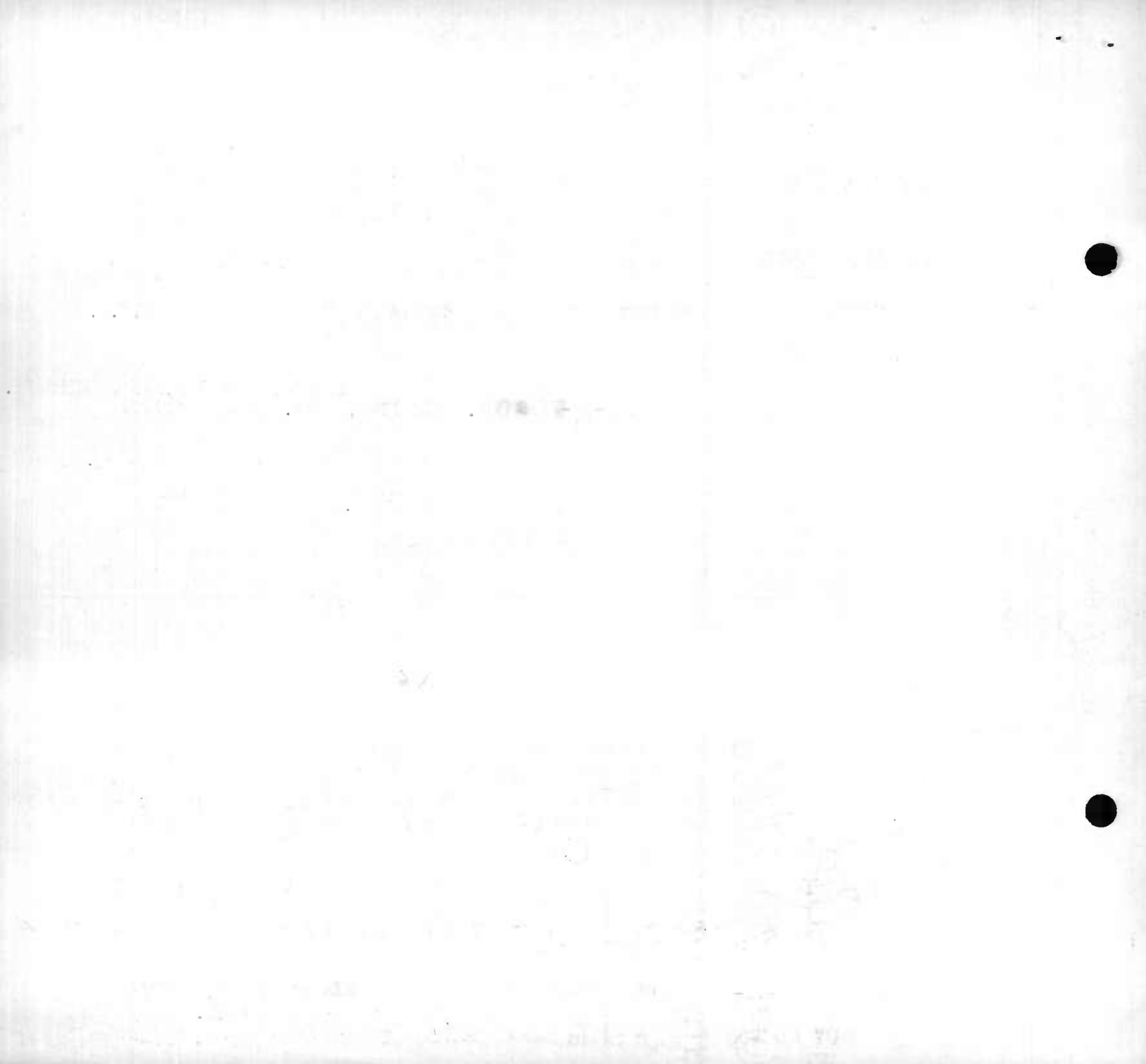
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CATHERINE M. FERGUSON		2. DATE AND HOUR OF DEATH 11-17-68 3:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO. MD. 21224		C. CITY OR TOWN DUNDALK		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 401 WESTFIELD RD. 21222		8. DATE OF BIRTH 12-12-25		9. AGE (In years lost birth day) 42	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME FRANKLYN EYRING		14. MOTHER'S MAIDEN NAME MARGARET WRIGHT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-10-3490		17. INFORMANT BCH RECORDS: 4940 EASTERN AVE. 21224	
18. 412.44-191X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		(A) IMMEDIATE CAUSE Cardiovascular collapse DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 h.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) Glucoscleroma in frontal area DUE TO, OR AS A CONSEQUENCE OF: partially removed		6 m.	
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II					
19A. DATE OF OPERATION 5/5/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN EDEMA		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Nov 16 1968 to Nov 17 1968 , that (I) (we) lost saw the deceased alive on Nov 17 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED 11/17/68		23C. PHYSICIAN'S NAME (Type) F. BACCI	
23D. ADDRESS BALTO CITY HOSPITALS 4940 EASTERN AVE. 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-20-1968	
24C. NAME OF CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE RECEIVED NOV 19 1968	
25B. NAME OF REGISTRAR Robert E. Fisher, MA		25C. FUNERAL DIRECTOR John J. Duda, Dundalk, Md. 21222		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11606
C-500		68-11606		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mollie COHEN		2. DATE AND HOUR OF DEATH 11-15-68 3:15 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION LEVIN DALE HEBREW HOME		A. STATE Md. B. COUNTY Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 8 INFIRMARY		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		8. DATE OF BIRTH May 1896
13. FATHER'S NAME MENDEL BORO		14. MOTHER'S MAIDEN NAME ANNA		9. AGE (In years last birthday) 72
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-30-8850		11. BIRTHPLACE (State or foreign country) RUSSIA
18. 250.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Urinary Infection		17. INFORMANT MR. JAKE FINN		12. CITIZEN OF WHAT COUNTRY? U.S.A.
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		13. CITIZEN OF WHAT COUNTRY? U.S.A.
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7-3- 19 62 to 11-15- 19 68 , that (I) (we) last saw the deceased alive on 11-15- 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]		23B. DATE SIGNED 11-15-68		23C. PHYSICIAN'S NAME (Type) for ARDAIZ, MD
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-18-68		24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR 6 BROS.
26A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		26B. NAME OF REGISTRAR Robert E. [Signature]		26C. FUNERAL DIRECTOR 6 BROS.
27A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		27B. NAME OF REGISTRAR Robert E. [Signature]		27C. FUNERAL DIRECTOR 6 BROS.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2-550 68-11607		BALTIMORE CITY HEALTH DEPT.		REG. NO. 68-11607	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Abraham Allen Zemon</i>		2. DATE AND HOUR OF DEATH <i>November 16, 1968 4 P.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>11-02</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Alcozar Hotel</i> <i>Madison & Cathedral</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>10-25-1898</i>		9. AGE (In years last birthday) <i>70</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Employee</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Concessionaire</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Jacob Zemon</i>		14. MOTHER'S MAIDEN NAME <i>Jeanne?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWI</i>		16. SOCIAL SECURITY NO. <i>218-22-5116</i>		17. INFORMANT <i>Mrs Sal Zemon - 6207</i>	
18. <i>410.0 I</i>		CAUSE OF DEATH		ADDRESS <i>Capeton Ave</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardio Respiratory Failure</i> <i>Acute Myocardial Infarction</i>			
		(B) <i>Its extensive Art C.V.I.D.</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>420.1 II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 25</i> 19 <i>58</i> to <i>Nov 16</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Nov 16</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>William D. Appleford</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>William D. Appleford</i>	
23D. ADDRESS <i>6615 Rustertown Rd</i>		24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-19-68</i>	
24C. NAME OF CEMETERY or CREMATORY <i>BALTIMORE NATIONAL</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 19 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Soldner & Sons</i>		25D. ADDRESS <i>6010 Rustertown Rd</i>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-425		68-11608		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11608	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Harry Preston Salzman</i>			
2. DATE AND HOUR OF DEATH <i>November 16, 1968 3:45 P.</i>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>25-41</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>4402 Haddon Ave</i>							
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 26, 1911</i>	9. AGE (In years last birthday) <i>57</i>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Automobiles</i>		11. BIRTH PLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Benjamin Salzman</i>			14. MOTHER'S MAIDEN NAME <i>Bessie Uogman (deceased.)</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>21603-5221</i>		17. INFORMANT <i>Mrs Rae Salzman - 4402 Haddon</i>		
18. <i>410.9 + 250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Acute myocardial infarction sudden.</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Arteriosclerosis Cardio-vascular disease.</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>20 yrs.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>420.1 II Diabetes Mellitus</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8/28/54</i> 19 to <i>11/15/68</i> 19, that (I) (we) last saw the deceased alive on <i>10/15/68</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>A. H. Silverman M.D.</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>11/18/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>A. H. Silverman, M.D.</i>				23D. ADDRESS <i>6210 Park Hts. Ave. Baltimore, Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Nov 18/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Har Zion Tifereth Israel Cemetery, Maryland</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 19 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MA</i>		25C. FUNERAL DIRECTOR <i>Sal Helinson - 6010 Reservoir Rd</i>		ADDRESS	

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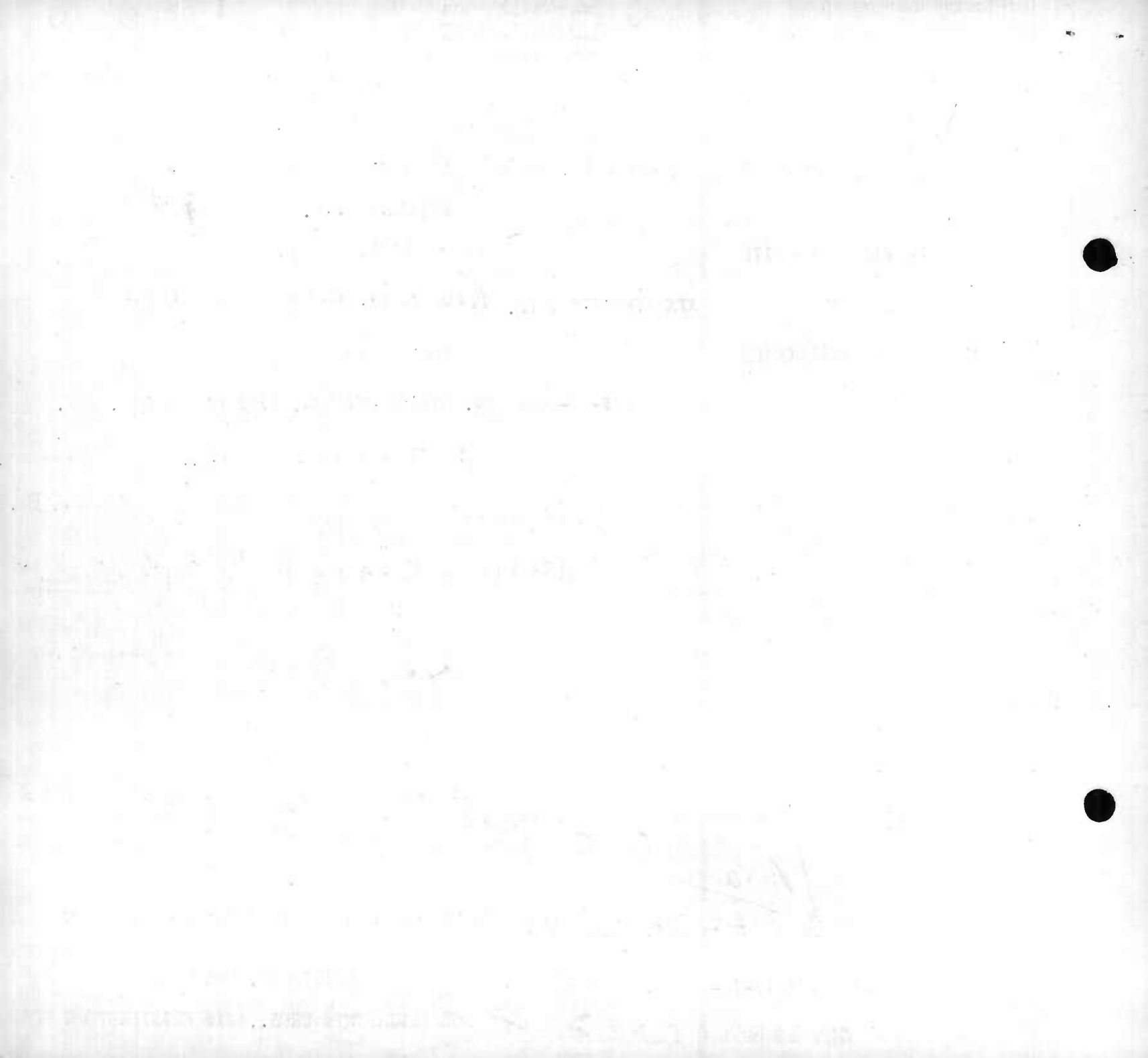
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-455-68-11609				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11609	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BESS SHULMAN				2. DATE AND HOUR OF DEATH 11-14-68 2:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LEVINDALE HEBREW HOMES INFIRMARY				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
91				E. STREET AND NUMBER ESPLANADE 13-01			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-16-1897	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESLADY		10B. KIND OF BUSINESS OR INDUSTRY XXX STEWARTS & CO.		11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MEYER SCHMUCKLER				14. MOTHER'S MAIDEN NAME TOBY ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-07-4826		17. INFORMANT ADDRESS MR. MILTON GOLDMAN, 5750 PARK HEIGHTS. AVE.			
18. 412141 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Acute Blood Loss thru Tracheostomy				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 hrs. 3 months			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. ASCVD = CVA x2 and Quadriplegia 2 yrs							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422.1 II							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-11-68 to 11-14-68 , that (I) (we) last saw the deceased alive on 11-14-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ardaiz				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) Jose AR DAIZ MD				23D. ADDRESS 7 OBERLIN COURT, Towson, 21204			
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 11-17-68		24C. NAME OF CEMETERY or CREMATORY OHEB SHALOM		24D. LOCATION (City, town, or county) (State) BALTIMORE, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11610

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) LOUIS NOCHUMOWITZ		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 14, 1968		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 14, 1968		Hour M. 9:00 A.	
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH APRIL 19, 1904		10. AGE (In years lost birthday) 64		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MENDEL NOCHUMOWITZ		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE	
15. MOTHER'S MAIDEN NAME CELIA SCHER		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT MRS. SARA TIMIN		19. ADDRESS 1148 W. HAMBURG ST. #21230		20. CAUSE OF DEATH Hypertensive and arteriosclerotic cardiovascular disease	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.2		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 443X II		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
24. DATE OF OPERATION 2		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) Yes	
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
30. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate		M.D.		DATE SIGNED November 14, 1968	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-17-68		24C. NAME OF CEMETERY or CREMATORY AHAVAS SHALOM	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		25D. ADDRESS 6010 REISTERSTOWN ROAD, BALTIMORE 21215			

ST. MARY'S
CHURCH

1914

APRIL 11, 1914

RECEIVED

U.S.A.

PAID TO THE

CELIA SCHER

COIN COX & SEAL

EDDIE

MR. SARA TUDIN, 1145 N. WASHINGTON ST., ST. LOUIS, MO.

NY

Constitution and By-Laws of the
National Association of Women

WALTER P. REED

1914

11-11-14

AMERICAN ASSOCIATION

RECEIVED

NOT FORWARDED BY THE POST OFFICE

1914

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11611

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)L.
JACOB GOLDEN2. DATE
OF
DEATHKnown ☒
Estimated ☐Month Day Year
November 14, 1968Hour
M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
OR INSTITUTION ADDRESS OR LOCATION)

Maryland General Hospital (DOA)

3. DATE
PRONOUNCED DEADMonth Day Year
November 14, 1968Hour
11:50 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

AUG 19, 1898

10. AGE (In years
lost birth day)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2601 Madison Street

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SAMUEL GOLDEN

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETAIL

14B. KIND OF BUSINESS OR INDUSTRY

MERCHANT

15. MOTHER'S MAIDEN NAME

BRINA ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

200-03-1512

18. INFORMANT

MRS. SHIRLEY GOLDEN, ADDRESS
TEMPLE GARDEN APTS. APT.
206A, 2601 MADISON AVE.19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Hypertensive and arteriosclerotic
cardiovascular diseaseAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 14, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

11-17-68

24C. NAME OF CEMETERY or CREMATORY

BETH TFILOH

24D. LOCATION (City, town, or county) (State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

NOV 18 1968

25B. NAME OF REGISTRAR

Robert E. Springate

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS. INC.

ADDRESS

6010 REISTERSTOWN ROAD, BALTIMORE 21215

August 1943

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68-11612 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11612

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ISADORE HARRIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 14 68 9:25 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour November 14 1968 9:25 p.m.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH APRIL 3, 1902		10. AGE (In years lost birthday) 66	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BERNARD HARRIS		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT MRS. ROSE HARRIS, 4218 LOWELL DRIVE #21208	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
21. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson EXAMINER'S NAME (Type)		M.D. November 13, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-17-68	
24C. NAME OF CEMETERY or CREMATORY SHAAREI ZION		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		ADDRESS 6010 REISTERSTOWN ROAD, BALTO. 21215	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-11613	
<div style="display: flex; justify-content: space-between;"> M-626 68-11613 CERTIFICATE OF DEATH </div>					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		MARRCHUCK, HENRY		NOVEMBER 18, 1968 10 ²⁵ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)		MD.		19-04	
BON SECOURS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 21223	
		D. STREET ADDRESS (If rural, give location)		1632 COLE STREET	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	CAUCASIAN	MARRIED	JUNE 4, 1884	84 YEARS	RETIRED TAILOR
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
TAILORING				RUSSIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
UNKNOWN		UNKNOWN		RUSSIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		NONE		217-01-0157 CHART	
18. 412.21		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO		Days	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.)		Cerebral Vascular Acc.			
ANTECEDENT CAUSES		(B) DUE TO		years.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Hypertensive B.S.C.V.D.			
443X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Nov. 8, 1968, to Nov. 18, 1968, that (I) (we) lost saw the deceased alive on Nov. 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Agustin del Campo. M.D.				Nov. 18, 1968	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
AGUSTIN del Campo M.D.		Bon Secours Hosp. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		11-22-68		Oak Lawn	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
BALTIMORE COUNTY Md.		Francis W. Miller		2101 Frederick Ave.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 20 1968		Robert E. Farber, Jr.		Francis W. Miller	

V-242

68-11614 BALTIMORE CITY HEALTH DEPARTMENT

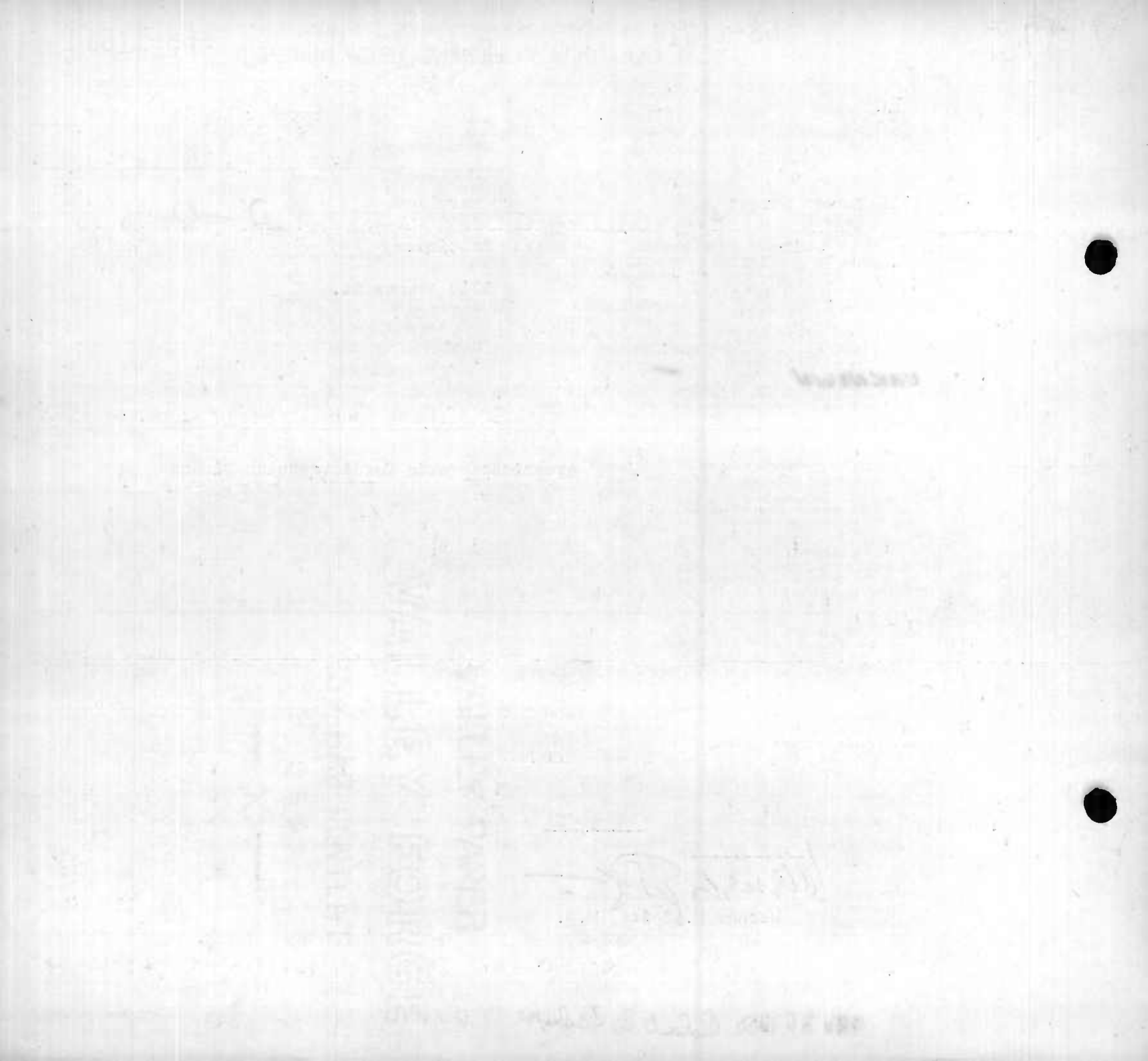
68-11614

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) STAMUS VASILAKES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 10, 1968 UNK M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1718 Thames Street		3. DATE PRONOUNCED DEAD Month Day Year Hour November 12, 1968 12:30 P.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH UNKNOWN		10. AGE (In years lost birthday) 72 Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? UNKNOWN	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		14B. KIND OF BUSINESS OR INDUSTRY UNKNOWN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		17. SOCIAL SECURITY NO. —	
18. INFORMANT ST. Nicholas Church, FLEET & PONCA STS.		ADDRESS	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 4.22.1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) No	
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 11/12/68			
24A. BURIAL CREMATION, REMOVAL, (Specify) BURIAL		24B. DATE 11-16-68	
24C. NAME OF CEMETERY or CREMATORY GREEK ORTHODOX CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR Robert E. Fickens	
25C. FUNERAL DIRECTOR Nicholas T. Matthews		ADDRESS 3021 EASTERN AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

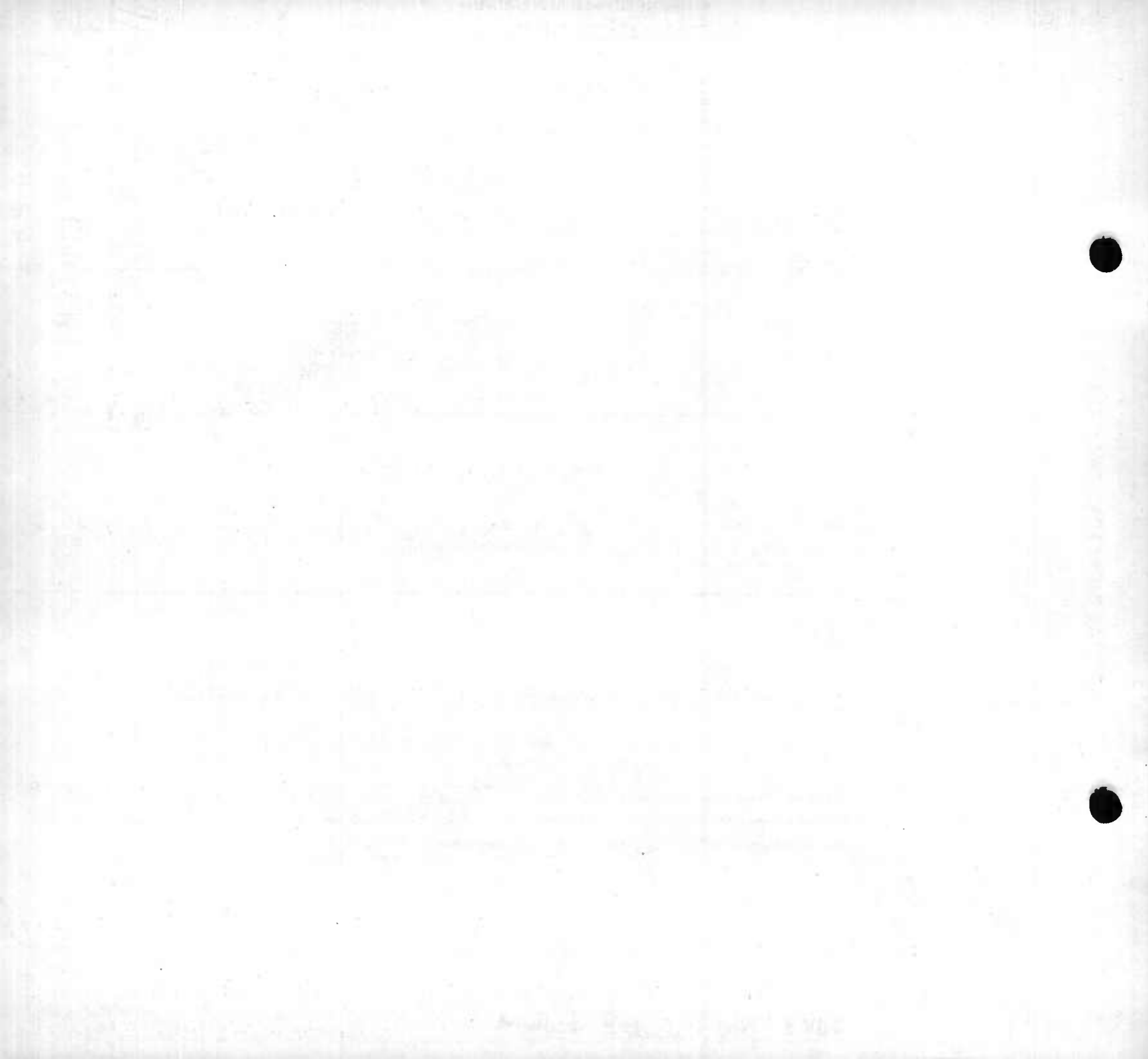
68-11615 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. X

68-11615

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Barbara Brooks</u>		2. DATE AND HOUR OF DEATH <u>11/17/68</u> <u>1:30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u> <u>53-00</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Hood Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4/20/1893</u>		9. AGE (In years last birthday) <u>75</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Mrs. Aldona Mikols</u> ADDRESS <u>104 N. 2nd St. Md.</u>	
18. CAUSE OF DEATH					
<p>157.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>Carcinoma of the pancreas with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>1 yr 3 mo.</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p>					
157X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/10</u> 19 <u>67</u> to <u>11/17</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/10</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Herbert J. Levickas</u> DEGREE				23B. DATE SIGNED <u>11/18/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u> DEGREE				23D. ADDRESS <u>5404 East Drive (21227)</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/20/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cem.</u>	
24D. LOCATION (City, town, or county) <u>Md.</u>		24E. ADDRESS <u>4430 Belair Rd. St. Johns</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 20 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkas</u>		25C. FUNERAL DIRECTOR <u>John J. Gowanlock Sr.</u>	



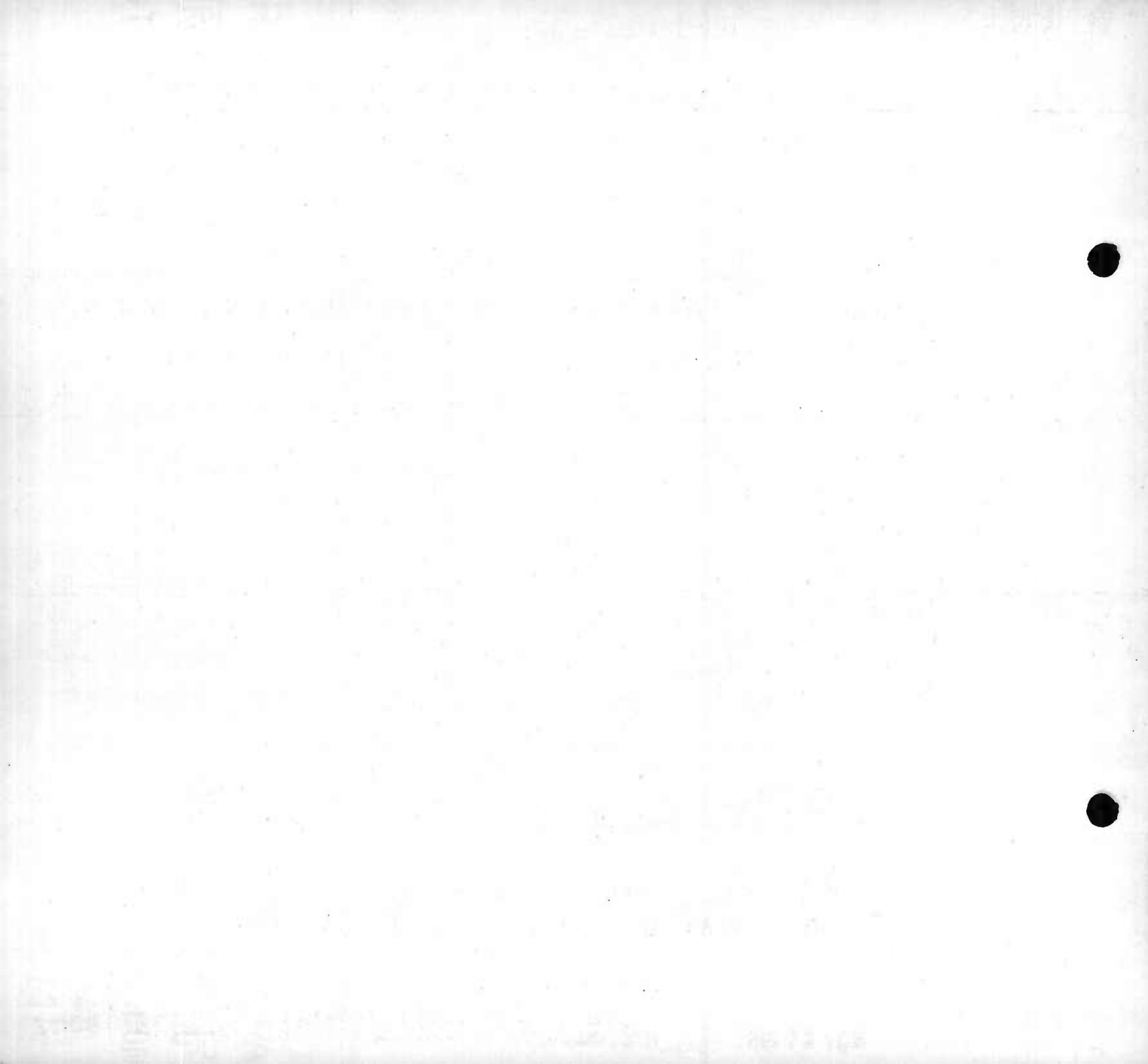
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11616 CERTIFICATE OF DEATH

REG. NO. 68-11616

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SISTER MARY LORETTA HARKINS		2. DATE AND HOUR OF DEATH NOVEMBER 16, 1968		P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 00 301 N. CALVERTON Road.				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 301 N. CALVERTON Road.							
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 7, 1876	9. AGE (In years lost birthday) 92	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NUN		10B. KIND OF BUSINESS OR INDUSTRY Religious		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Records, 301 N. CALVERTON Rd.			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction Arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 1964 to Nov 19 68 , that (1) (we) last saw the deceased alive on 11-13- 19 68 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A.E. WALSH MD				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11-18-68	
23C. PHYSICIAN'S NAME (Type) A.E. WALSH MD				23D. ADDRESS 222 St. PAUL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-19-68		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR Robert E. Forbush		25C. FUNERAL DIRECTOR Geo. L. Schuch Funeral Home Francis H. Miller 2101 Franklin Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11617 CERTIFICATE OF DEATH

REG. NO. 68-11617

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mary Agnes Bell		2. DATE AND HOUR OF DEATH November 18, 1968 12:05 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 15-10		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3501 Berwyn Avenue 21215		E. STREET AND NUMBER 3501 Berwyn Ave. 21215	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1895	9. AGE (in years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mach Operator		10B. KIND OF BUSINESS OR INDUSTRY National Linen & Thread		11. BIRTHPLACE (State or foreign country) Pittsburgh, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Walter Schohn		14. MOTHER'S MAIDEN NAME ? Walters	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. George W. Lang 5507 Daywalt Ave. 21206	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Sept. 30, 1968 to Nov. 18, 1968 , that (I) (we) last saw the deceased alive on Nov. 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Abraham B. Hurwitz M.D.		23B. DATE SIGNED Nov. 19, 1968		23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ, M.D.	
23D. ADDRESS 7501 Liberty Road, Baltimore, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/20/68	
24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Bitchie Highway A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR McAulley F.H.		25D. ADDRESS 237 Patapsco Ave. 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11618</u>
BIRTH NO. 1. NAME OF DECEASED (Type or Print) ANACKER, CHARLES GEORGE		68-11618 CERTIFICATE OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		2. DATE AND HOUR OF DEATH NOVEMBER 18, 1968 1:25P M.		
5. SEX MALE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED DISTILLER		8. DATE OF BIRTH 08/27/90 9. AGE (In years lost birthday) 78		
10B. KIND OF BUSINESS OR INDUSTRY UNITED DISTILLERY		11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HERMAN ANACKER		14. MOTHER'S MAIDEN NAME WILHEMINIA ANACKER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 217-05-0150		
17. INFORMANT ST. AGNES HOSPITAL RECORDS		ADDRESS		
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE ASCVD DUE TO, OR AS A CONSEQUENCE OF: (B) Old MI, Coriary Anauuff DUE TO, OR AS A CONSEQUENCE OF: (C) Possible Pulmonary Embolus (?)				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 1 yr. > 1 yr. < 2 days				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0				
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —				
20A. AUTOPSY? (Yes or No) NO				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 22 1968 to NOVEMBER 18 1968 , that (I) (we) last saw the deceased alive on NOVEMBER 18 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Walter B. Blumberg, M.D.				
23B. DATE SIGNED 11/18/68				
23C. PHYSICIAN'S NAME (Type) MORTON BLUMBERG				
23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				
24B. DATE 11-21-68				
24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery				
24D. LOCATION (City, town, or county) (State) Baltimore City, Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968				
25B. NAME OF REGISTRAR Robert E. Hubbard				
25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229				

RECEIVED

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11619

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11619

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Catherine M. Reichert

2. DATE AND HOUR OF DEATH

November 17, 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

407 East Lynn Avenue
Baltimore, Maryland 21223

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

407 East Lynn Avenue 21223

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

2-4-1899

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

Daniel E. Reichart, Jr. 5015 Wilkens Ave. 27

ADDRESS
Baltimore

18. 1912-1-23-8-9

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Malignant Cerebral
Astrocytoma

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

7 mos

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

193.0 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Diabetes Mellitus

19A. DATE OF OPERATION

June 13, 1968

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED
Cerebral Tumor

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Not While
Work ☐ At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 68 to Nov 17 1968.
that (I) lost saw the deceased alive on Nov 16 1968 and that in (my) opinion death occurred on the date
and hour and from the causes stated above. (I) (did) (did not) view the body after death.

23A. SIGNATURE

Earl Pass MD

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

11-18-68

23C. PHYSICIAN'S
NAME (Type)

EARL PASS MD

23D. ADDRESS

4001 Wilkens Ave

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-21-68

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

Baltimore City, Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 20 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

Howard H. Hubbard 4107 Wilkens Ave 21229

ADDRESS

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100-2-3
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100-2-3

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100-2-3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11620
BIRTH NO.		68-11620		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
VARBLE. WILLIAM HENRY		11/18/68		9 15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD		B. COUNTY	
UNION MEMORIAL HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3966 ELM AVENUE			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-10-05	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min. 2 8
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY Lord Balto. Hotel		11. BIRTHPLACE (State or foreign country) KENTUCKY	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME ALONZO VARBLE		14. MOTHER'S MAIDEN NAME FLORENCE SIMMONS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11/24/23-12/2/27		16. SOCIAL SECURITY NO. 212-07-1938		17. INFORMANT Mrs. Wesleyna Varble-3966 Elm Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION last. 151X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIORESPIRATORY ARREST (B) STARVATION (C) CARCINOMA OF STOMACH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 minutes 2 months 2 1/2 months	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 11/9 1968 to 11/15 1968, that (I) (we) last saw the deceased alive on 11/15 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Carlos A. Lea Plaza		23B. DATE SIGNED 11/18/68		23C. PHYSICIAN'S NAME (Type) CARLOS A. LEA PLAZA MD. CARLOS A. LEA PLAZA	
23D. ADDRESS 110 W. 34 ST. BALTO MD.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/21/68	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968	
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Austin E. Donovan-3818 Roland Ave.			

✓

3500 ELM AVENUE

OF K-02 03 1 58

KENTUCKY

FLORENCE CIVIL

CARDINAL

STATION
CARDINAL DE

NO

1000 N. 1st St.

X

M

REPORTER

ALONSO VARGAS

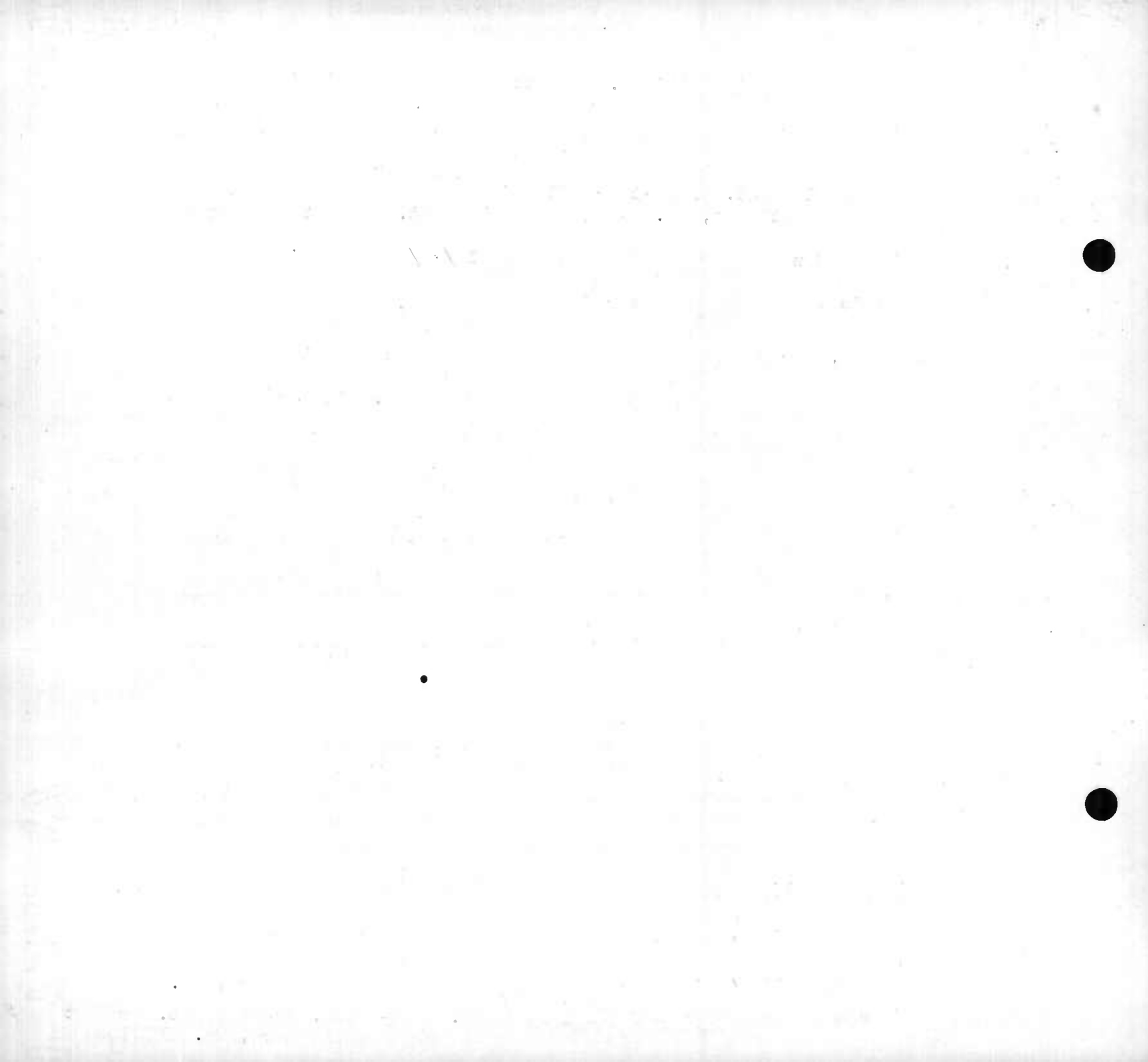
Alonso

CARDINAL A 1000 N 1st St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11621
BIRTH NO.		68-11621		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Mamie (Mimi) P. Parrott			11/19/68		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 60 1001 St. Paul St Apt J2 Baltimore, Md. 21202			A. STATE Md		
			B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER			1001 St. Paul St Apt J2		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	Cau		12/29/82	85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Companion		Retired		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James R. Perry			Alice Hindle		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Madeline A. FitzGerald Same as "E" Apt 4H	
18. 412.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Infected blood</i> (B) <i>Myocardial infarction (for 11 years)</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1957 to Nov. 1968, that (I) (we) last saw the deceased alive on October 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Wm. P. Hamburger Jr.			11/19/68		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Wm. P. Hamburger Jr.			1001 St Paul St Baltimore Md 21202		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		11/11/20/68		Greenmount	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 20 1968		Robert E. Jankins		Wm. Cook-Brooks Inc 1217 St. Paul St Baltimore, Md. 21202	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11622 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 68-11622	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MAITZIE FINCHUM, MAITZIE VIRGINIA		2. DATE AND HOUR OF DEATH NOVEMBER 18, 1968 7:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 21229, MD.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 25-04			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-08-14	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKER		10B. KIND OF BUSINESS OR INDUSTRY MC CORMICK & CO.		9. AGE (In years lost birthday) 54	
13. FATHER'S NAME IRA PAINTER		14. MOTHER'S MAIDEN NAME MATTIE (HOFFMAN) PAINTER		11. BIRTHPLACE (State or foreign country) VIRGINIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 226106459		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. INFORMANT ST. AGNES HOSPITAL, WILKENS & CATON AV		ADDRESS			
18. 734.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Meningitis (gram negative rod) (B) Peritonitis (following jejunal resection) (C) Mechanical Obstruction (of acute lyeus nephritis) (Lyeus nephritis diagnosed approx. 2 weeks ago)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days	
19A. DATE OF OPERATION 11/12/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Small bowel obstruction		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 25 19 68 to NOVEMBER 18 19 68 , that (I) (we) last saw the deceased alive on NOVEMBER 18 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Morton B. Blumberg, M.D.		23B. DATE SIGNED 11/18/68		23C. PHYSICIAN'S NAME (Type) MORTON B. BLUMBERG	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/21/68		24C. NAME OF CEMETERY or CREMATORY Spaders Church Cemetery	
24D. LOCATION McGaheysville		24E. STATE Va		24F. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR Robert E. Jarboe		25C. FUNERAL DIRECTOR Mc Gully E. H. V37 Fatapsoo Ave	

V.S. 153

12-2-68

M.H.

F-200

BALTIMORE CITY HEALTH DEPARTMENT
68-11623 CERTIFICATE OF DEATH

REG. NO. 68-11623

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

George Fogg, W.

2. DATE AND HOUR OF DEATH

11/19/68 4:49 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)THE JOHNS HOPKINS HOSPITAL
BALTIMORE MD 212054. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MD

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1721 E. BIDDLE ST. 21213

5. SEX

M

6. RACE

N

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-23-1913 55

9. AGE (In years
last birthday)If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STEEL WORKER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VAUGHAN, N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

GEORGE W. FOGG

14. MOTHER'S MAIDEN NAME

ANNA GREEN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown; if yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

LUCILLE FOGG - 1721 E. BIDDLE ST.

ADDRESS

18.

412.2 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Probable CVA
Hypertensive ArteriosclerosisAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF:

years

(C)

MEDICAL CERTIFICATION

H43X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

NO

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____,
that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David A. Bass

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11/19/68

23C. PHYSICIAN'S
NAME (Type)

DAVID A. BASS

23D. ADDRESS

JOHNS HOPKINS HOSPITAL

DEGREE

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

11/22/68

24C. NAME of CEMETERY or CREMATORY

MT. CALVARY CEM.

24D. LOCATION

A.A. COUNTY

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 20 1968

25B. NAME OF REGISTRAR

Robert E. Feltner

25C. FUNERAL DIRECTOR

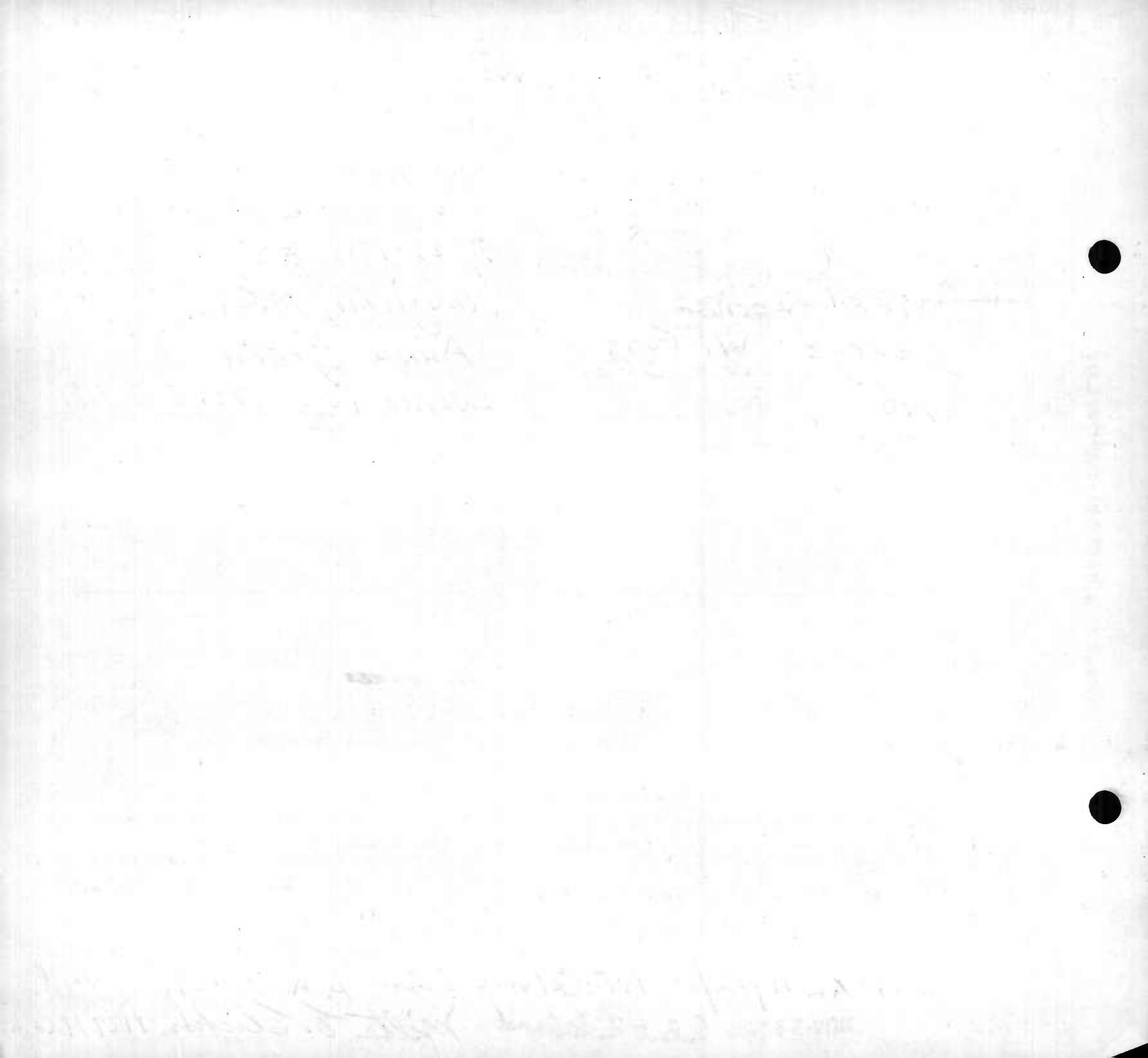
Milton E. Edickson

ADDRESS

1129 N. Carol

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

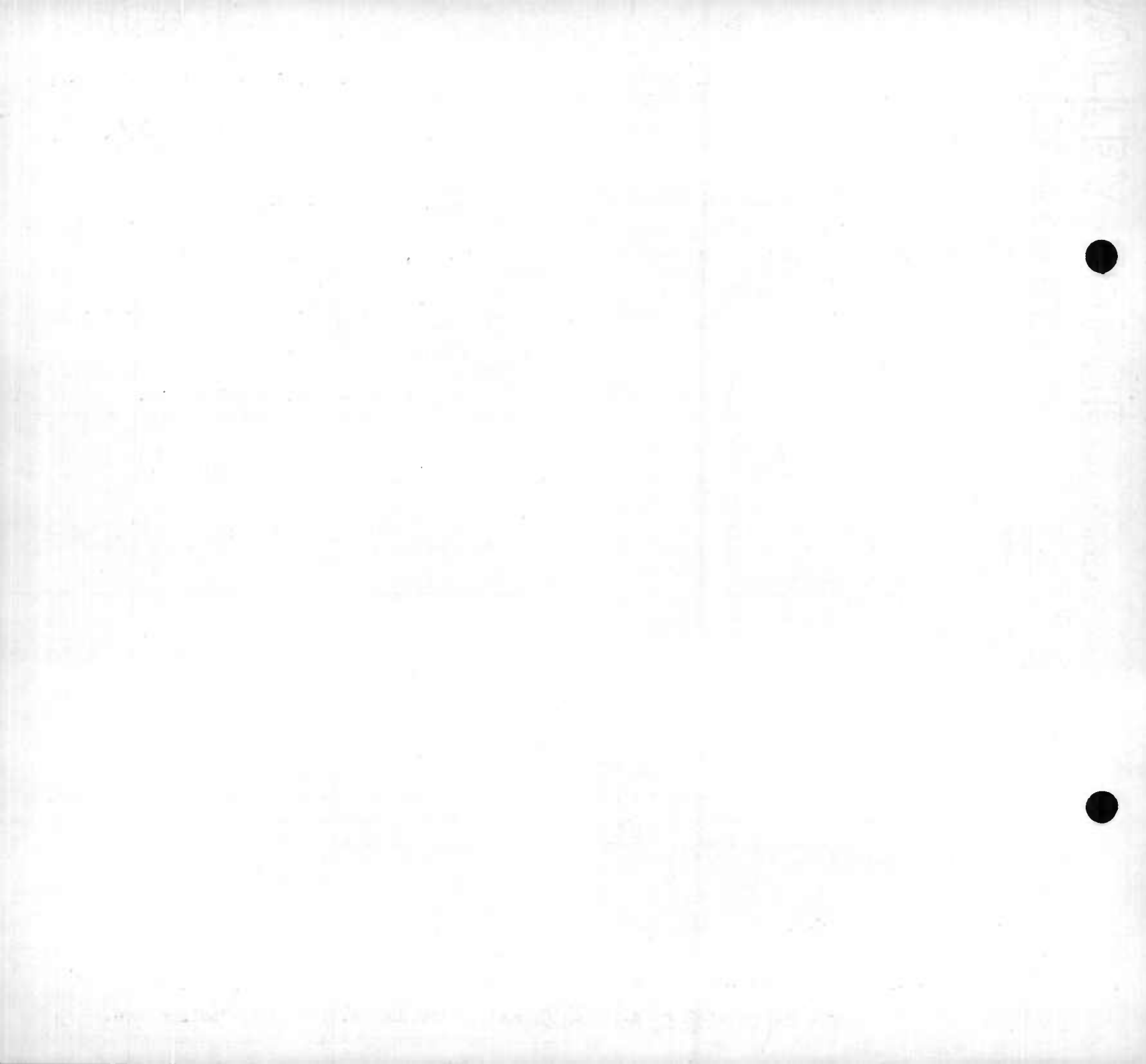


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11624 CERTIFICATE OF DEATH

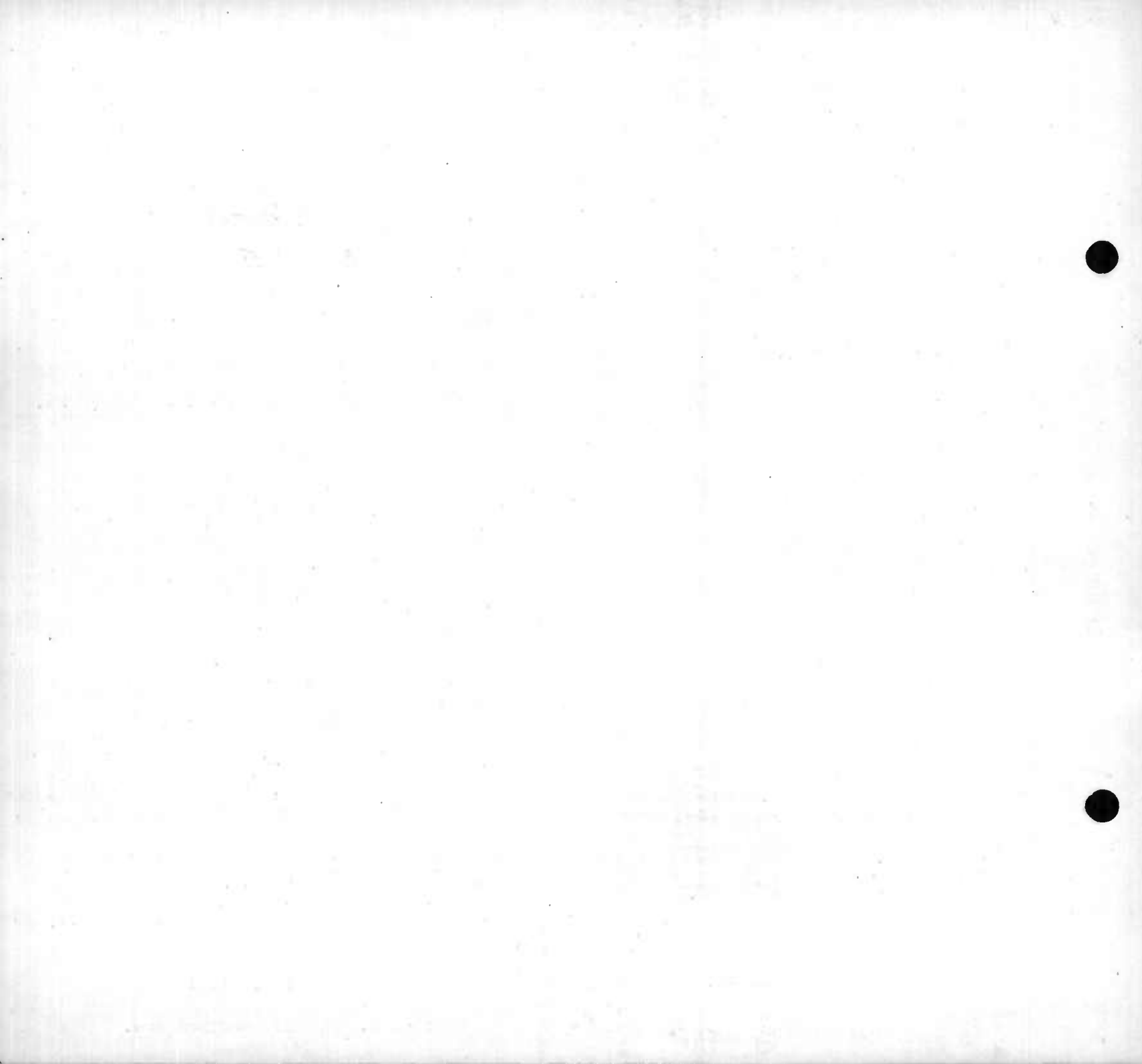
REG. NO. 68-11624

BIRTH NO.		1. NAME OF DECEASED (Type or Print) RALPH J. YOUNG		2. DATE AND HOUR OF DEATH NOV. 15, 1968 9:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 3232 CARLISLE AVENUE		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-37 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3232 CARLISLE AVENUE			
5. SEX MALE	6. RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 27, 1893	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN		10B. KIND OF BUSINESS OR INDUSTRY SELF		11. BIRTHPLACE (State or foreign country) KNOXVILLE, TENN.	
13. FATHER'S NAME AARON YOUNG		14. MOTHER'S MAIDEN NAME KATHERINE SPEARS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 220-44-5086		17. INFORMANT ADDRESS LOIS YOUNG - 3232 CARLISLE AVE.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Ante-mortem Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1968</i> to <i>Nov. 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov. 13, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard D. Hahn, M.D. / R.T.S.</i> DEGREE				23B. DATE SIGNED 11/18/68	
23C. PHYSICIAN'S NAME (Type) RICHARD D. HAHN, M.D. DEGREE				23D. ADDRESS 2106 SOUTH RD., BALTO. RD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-19-68		24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS CHARLES R. LAW 802 Madison Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11625	
68-11625 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Bertha Stephens (Nee Chaney)		2. DATE AND HOUR OF DEATH November 18th 1968 9:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Balto		
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital			C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2147 W. LEXINGTON St.		
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/1923	9. AGE (in years last birthday) 45	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Worker		10B. KIND OF BUSINESS OR INDUSTRY Glass Worker		11. BIRTHPLACE (State or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Robt. Chaney		
14. MOTHER'S MAIDEN NAME Frances Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) /		
16. SOCIAL SECURITY NO. 223 12-0322			17. INFORMANT ADDRESS Samuel Stephens - 2147 W. Lexington St.		
18. 199.0 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Terminal Ca with pleural effusion					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
19. 199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from October 7th 1968 to November 18th 1968 , that (I) (we) last saw the deceased alive on November 18th 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael G. [Signature]				23B. DATE SIGNED 11/18/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-23-68		24C. NAME of CEMETERY or CREMATORY Mt. Pleasant	
24D. LOCATION (City, town, or county) (State) Halifax, Virginia		25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968			
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave.			



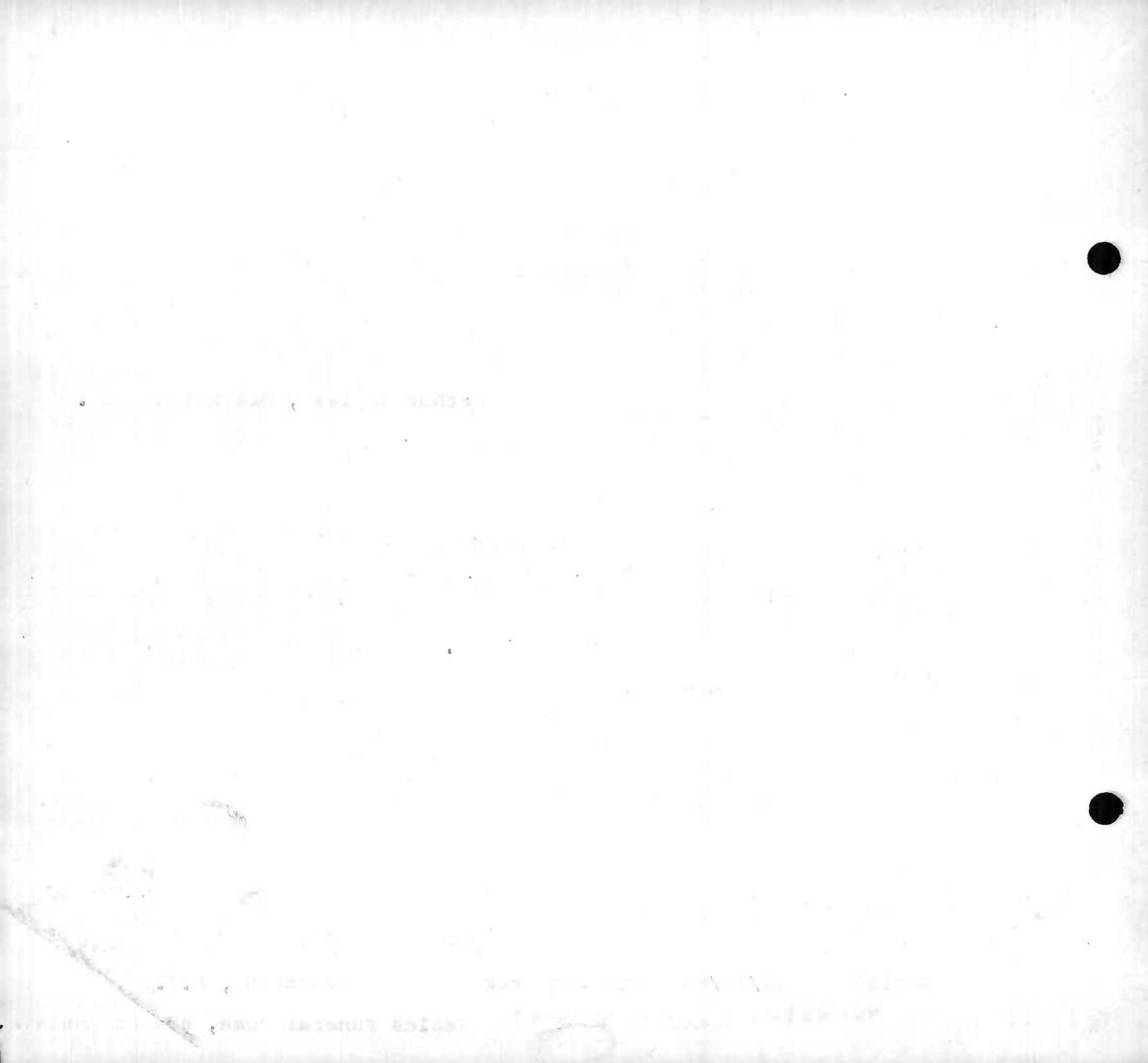
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11626 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11626

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JAMES MITCHELL SMITH.</u>		2. DATE AND HOUR OF DEATH <u>NOVEMBER 14 1968 9:55 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>17-03</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MARYLAND HOSPITAL.</u> <u>38</u>		E. STREET AND NUMBER <u>407 MYRTLE AVE 21201</u>			
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/13/21</u>	9. AGE (in years last birthday) <u>47</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>V.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>James Smith.</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Brown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Arthur Waples, 824 Kaighn Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>157.9 I</u> CAUSE OF DEATH <u>Carcinoma of Pancreas Metastatic</u> (A) IMMEDIATE CAUSE <u>Diffusely</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Upper Gastrointestinal Bleed (aspiration)</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Chronic Alcoholism</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>60-65-1 Year</u> <u>24 hours</u> <u>Years</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>157X II</u> <u>Chronic alcoholism & esophageal varices</u>					
19A. DATE OF OPERATION <u>11/6/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Esophageal Varices</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <u>September 27, 1968</u> to <u>November 14, 1968</u> , that (I) was last saw the deceased alive on <u>November 14, 1968</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.					
23A. SIGNATURE <u>Joel Mayer Cherry, M.D.</u>		23B. DATE SIGNED <u>November 14, 1968</u>		23C. PHYSICIAN'S NAME (Type) <u>Joel Mayer Cherry</u>	
23D. ADDRESS <u>University of Maryland Hospital Balto, Md.</u>		23E. NAME OF CEMETERY or CREMATORY <u>Woodstown, N.J.</u>		23F. LOCATION (City, town, or County) (State)	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/18/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Morning Star</u>	
24D. DATE RECEIVED <u>NOV 20 1968</u>		24E. NAME OF REGISTRAR <u>Robert E. Salyers</u>		24F. FUNERAL DIRECTOR <u>Waples Funeral Home, 824 Kaighn Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68-11627					Registered No. 68-11627				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>Gladys Palechia Randolph (King)</i>					2. DATE AND HOUR OF DEATH <i>11/15/68 10:53 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>3305 Winterbourne Rd. Baltimore</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>16-07</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
					D. STREET ADDRESS (If rural, give location) <i>3305 Winterbourne Rd.</i>				
5. SEX <i>Fe.</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>10/23/02</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>US.</i>		
13. FATHER'S NAME <i>Charles Banks.</i>					14. MOTHER'S MAIDEN NAME <i>Annie Yerby.</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-14-5915</i>		17. INFORMANT <i>Mrs Anna Williams</i>			ADDRESS <i>3305 Winterbourne</i>		
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Myocardial Infarction</i> <i>Arteriosclerotic Cardiovasc. disease</i>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
18. <i>420.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>1st Sept. 1968</i> to <i>11/15/68</i> 19 <i>68</i> that (I) (we) last saw the deceased alive on <i>11/12/68</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Alvin Thompson</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>11/15/68</i>	
13C. PHYSICIAN'S NAME (Type) <i>Alvin Thompson</i>					23D. ADDRESS <i>1856 N. Wolfe St. Baltimore 21213</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/18/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 20 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fasham</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Charles R. Law, 802 Madison Ave.</i>				

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Example

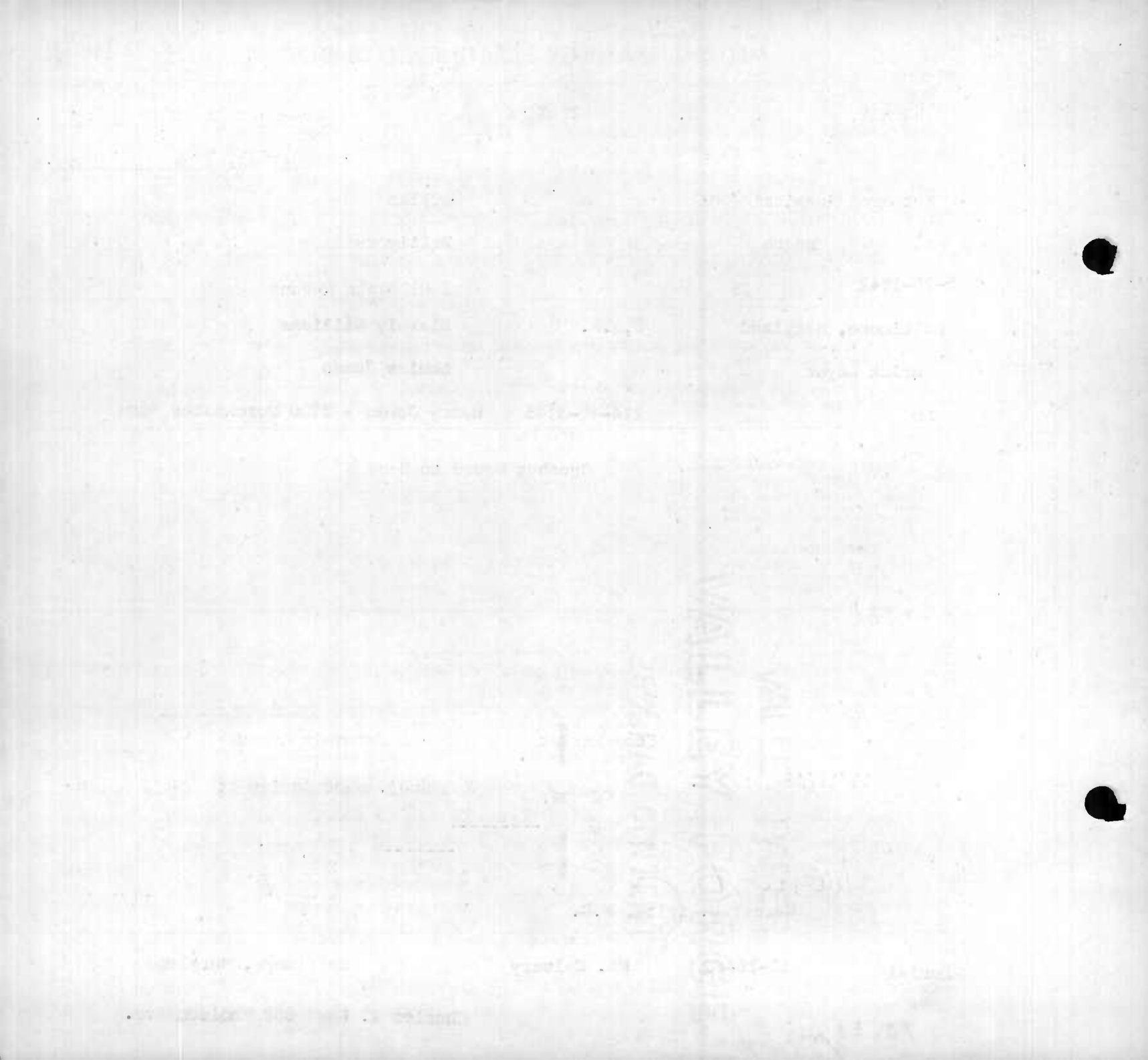
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11628

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RODNEY B. WILLIAMS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 11, 1968 6:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 11, 1968 7:00 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5-25-1942	10. AGE (In years last birthday) 26	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Blakely Williams	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Louise James		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 214-40-3145		18. INFORMANT ADDRESS Henry James - 3700 Dorchester Road	
19. E 965 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Gunshot Wound to Head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 423 Normandy Avenue	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Food Market	
22C. TIME (Month) (Day) (Year) (Hour) 11/11/68 6:30 P.		22D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22E. HOW DID INJURY OCCUR? Subj. shot during attempted holdup		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 11/12/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-16-68	
24C. NAME of CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11629 CERTIFICATE OF DEATH

REG. NO. 68-11629

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SARAH MCCREE		2. DATE AND HOUR OF DEATH 11-16-68 425 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 18 Md. General Hosp.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY MD C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 900 N. Bentall St.	
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-11	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dietary-Hutzelers		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Wayman Brown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-11-3371		17. INFORMANT ADDRESS Hosp. info. sheet	
18. 180 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Carcinoma of cervix		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of cervix (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/67	
171 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 11-11-68, 11-15-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-9 19 68 to 11-16 19 68 , that (I) (we) last saw the deceased alive on 11/16 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE Marvin C. Sachs				23B. DATE SIGNED 11-16-68	
23C. PHYSICIAN'S NAME (Type) MARVIN C. SACHS		23D. ADDRESS Md. Gen. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-20-68		24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park	
24D. LOCATION (City, town, or county) (State) Laurel, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS CHARLES R. LAW - 802 MADISON AVE.			

My friend, Mary

F N X

Weyman Brown
P.O. Box 1000

8-11-10

Virginia
Unknown

Carroll at center
2-1-10

10-11-10

Carroll at center

11/10

Weyman Brown

Weyman Brown

My friend

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68-11630 CERTIFICATE OF DEATH

REG. NO. 68-11630

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary J. Thomas		November 12, 68 5:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
00 2408 Montebello Terrace			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2408 Montebello Terrace		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	Colored	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7/4/1879	89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Va.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
John Bibbs			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				Robert Williams,	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic heart Disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis		
			(C) ...		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
0					
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
no					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 1968 to Nov. 12 1968, that (I) (we) last saw the deceased alive on Nov. 11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
F. K. Adams			11-15-68		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
F. K. ADAMS			1222 N. Caroline St. Baltimore Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	11/16/68	Arbutus Mem. park		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 20 1968		Robert E. Fisher		Charles R. Law, 802 Madison Ave.	

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Antennae - 11

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Nov 11 1898

F. A. Adams
J. K. Adams

11-11-98

FUNERAL DIRECTOR: IMPORTANT

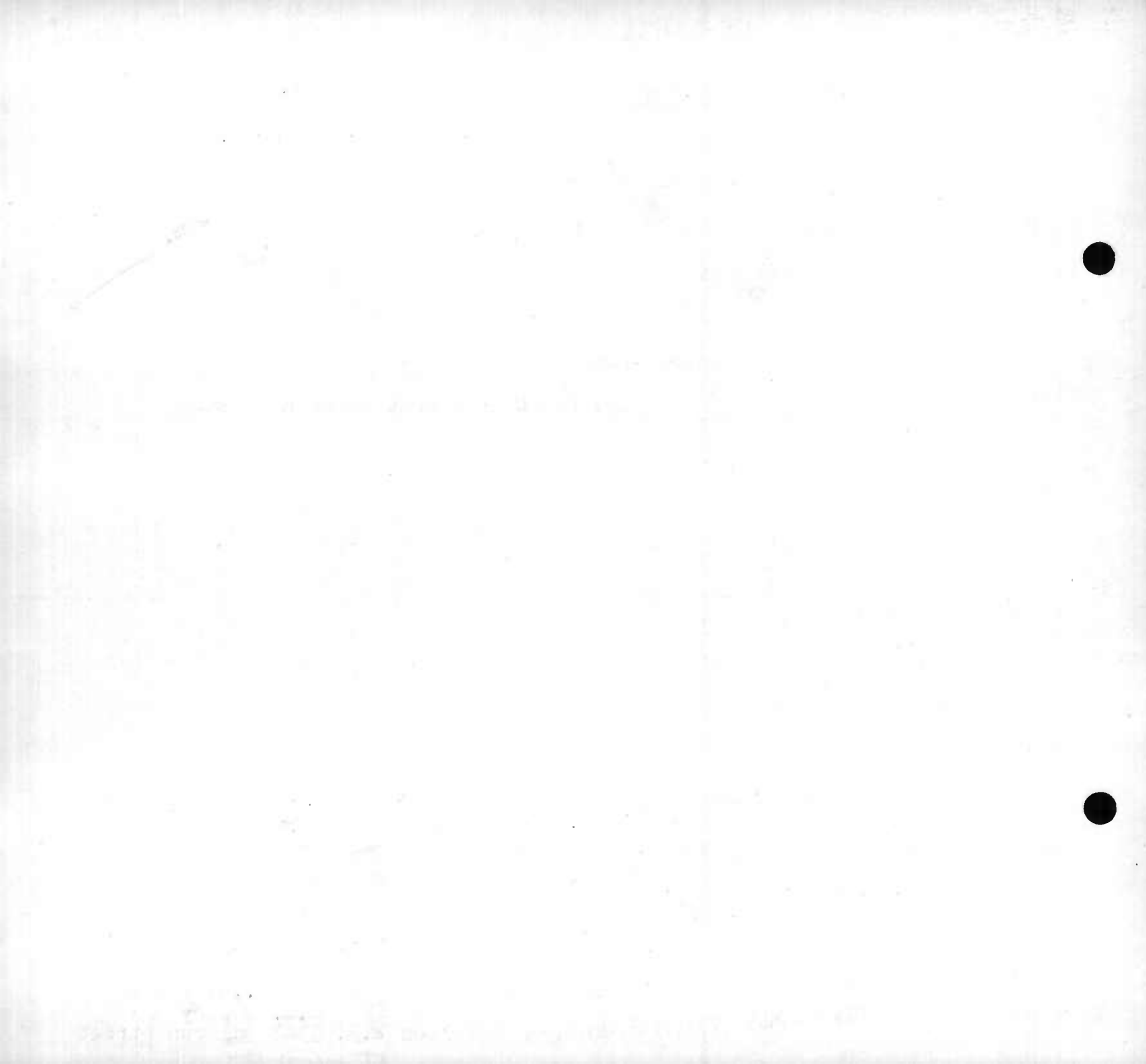
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11631

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11631

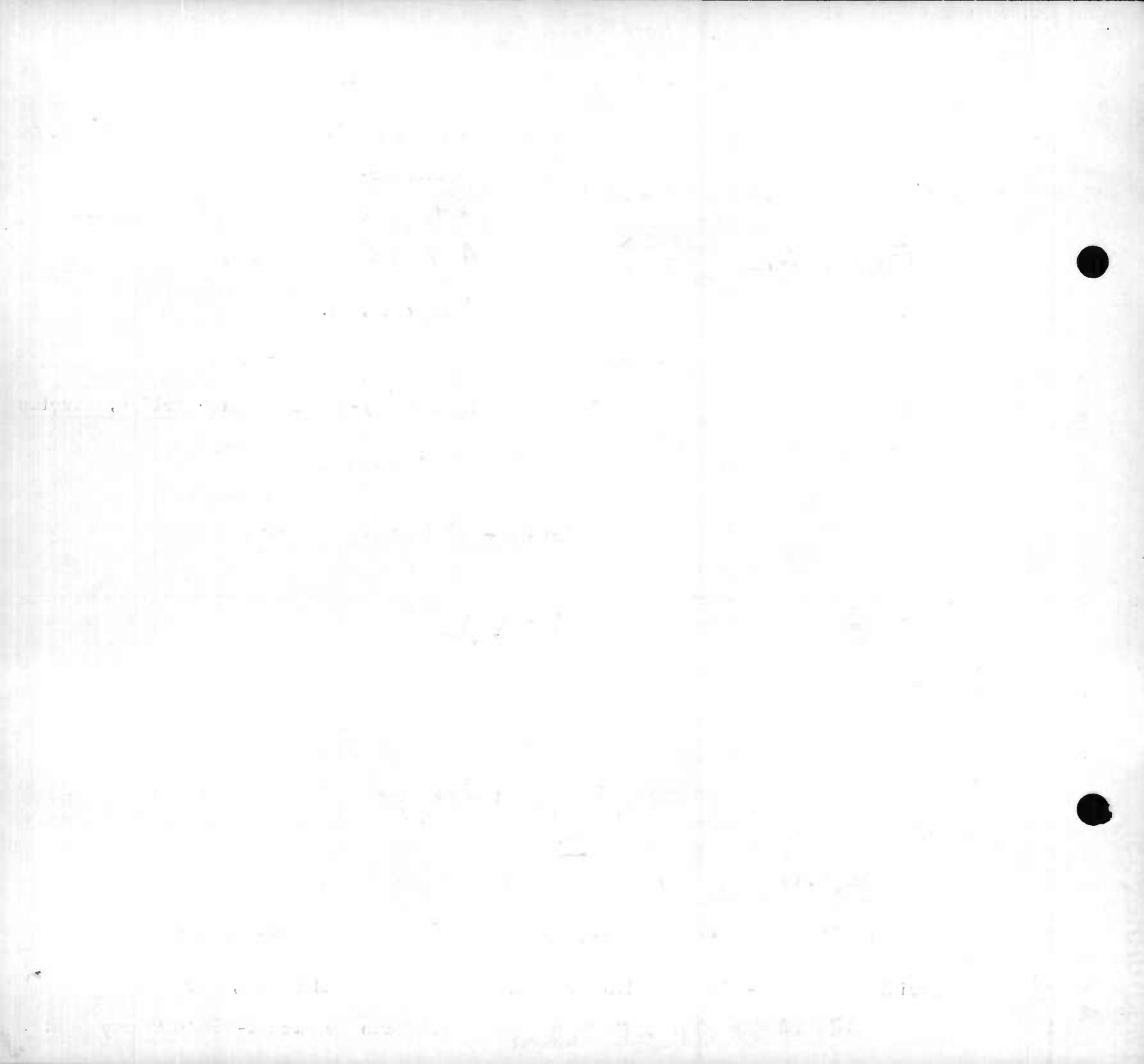
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Herbert Thomas</i>		2. DATE AND HOUR OF DEATH <i>17 November 1968 2²⁰ PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>2431 West Lombard Ave</i>					
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/19/21</i>	9. AGE (In years last birthday) <i>47</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Truck driver</i>		11. BIRTHPLACE (State or foreign country) <i>No CAROLINA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Andrew Thomas</i>		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>227120660</i>		17. INFORMANT <i>Margaret Johnson</i> ADDRESS <i>same</i>	
18. <i>400.0</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>[REDACTED]</i> (B) <i>Malignant hypertension</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>17 Nov 1968</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>G.I. bleeding</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>he</i> (this hospital) attended the deceased from <i>5 November 1968</i> to <i>17 November 1968</i> , that <i>he</i> (we) last saw the deceased alive on <i>17 November 1968</i> and that in <i>our</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>He</i> (We) (did) <i>not</i> view the body after death.					
23A. SIGNATURE <i>Morris Ostroff, MD</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>17 November 68</i>	
23C. PHYSICIAN'S NAME (Type) <i>MORRIS OSTROFF, MD</i>		23D. ADDRESS <i>Sinai Hospital of Baltimore</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>11-22-68</i>	24C. NAME OF CEMETERY or CREMATORY <i>Church Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Sussex Co., Virginia</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 20 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>V.R. Bailey</i> ADDRESS <i>Kelson F.H. 1348 Calhoun Street</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X 68-11632
BIRTH NO. 68-11632		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>AMEY, GERTRUDE</u>		2. DATE AND HOUR OF DEATH <u>11.19.68</u> <u>13:30</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 Sinai Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>BALTIMORE</u> B. COUNTY <u>MARYLAND</u> <u>53-00</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <u>8430 Greenway Rd.</u> <u>21234</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. XXXX NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>4-7-05</u>	9. AGE (In years last birthday) <u>63</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Coatsville, Pa.</u>
13. FATHER'S NAME <u>Morton</u>		14. MOTHER'S MAIDEN NAME <u>Bethel</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Milton Amey-Box 518 Union Bridge, Maryland</u>	
18. <u>039.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>UREMIA.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>GRAU - SEPTIC SHOCK.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION <u>05-4X</u> II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ASVD-</u>		
20A. AUTOPSY? (Yes or No) <u>0</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>11-18-68</u> 19 to <u>11-19-68</u> 19, that (I) (we) last saw the deceased alive on <u>11.19.68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death.				
23A. SIGNATURE <u>J.R. Chloca, M.D.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>I. R. Chloca, interne</u>
23D. ADDRESS <u>Sinai Hospital</u>		23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11-22-68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 20 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Ellsworth Armacost-4600 Liberty Hghts.</u>



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11633

BIRTH NO. 68-21146

REG. NO. X

1. NAME OF DECEASED (Type or Print) NANETTE WOLFE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 11 Day 17 Year 68 Hour 5:45 p.m. Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION City Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month November Day 17 Year 1968 Hour 5:45 p.m.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. ESSEX	
9. DATE OF BIRTH Nov. 7 1968		10. AGE (In years lost birthday) 10 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME PATRICIA HANDY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT JAMES WOLFE		ADDRESS ABOVE	
19. 795 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 793.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Sudden death in infancy DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Edward F. Wilson, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 18, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 11/17/68	
24C. NAME OF CEMETERY or CREMATORY ROSELAWN		24D. LOCATION (City, town, or county) (State) MARTINSVILLE VA.	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR J. G. CONNELLY SONS		ADDRESS 300 MACE	

1/10

James C. White

James C. White

James C. White

James C. White

James C. White

James C. White

James C. White

James C. White

James C. White

James C. White

James C. White

James C. White

James C. White

James C. White

James C. White

James C. White

James C. White

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11634 CERTIFICATE OF DEATH

REG. NO. 68-11634

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mrs. Annie A. Connolly		2. DATE AND HOUR OF DEATH November 11, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 6027 Falkirk Road		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 27-38 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6027 Falkirk Road			
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1886	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Brushmiller		14. MOTHER'S MAIDEN NAME Mary Kelly	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-54-6171		17. INFORMANT Mrs. Thomas F. Conelius 6027 Falkirk Rd.	
18. 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Generalized Arteriosclerosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs.	
19. 450.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Bilateral pneumonia		2 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 21, 1942 to November 11, 1968 , that (I) (was) last saw the deceased alive on November 11, 1968 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE Wm. H. Grenzer DEGREE				23B. DATE SIGNED 11.12.68	
23C. PHYSICIAN'S NAME (Type) Dr. William H. Grenzer DEGREE				23D. ADDRESS 1520 E. 33rd St.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 11/14/68		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd. #21212	

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m-600

68-11635 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11635

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

KURT MAYER

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

HOSPITAL

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4014 W. Rogers Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 16, 1968

5:00 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Feb 22, 1909

10. AGE (In years
lost birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

E. STREET AND NUMBER

4014 W. Rogers Avenue

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Richard

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Accountant

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Bartha

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO YES WORLD WAR II

17. SOCIAL
SECURITY NO.

220-09-7592

18. INFORMANT

Otto Mayer

ADDRESS

6972 Millbrook Park Drive

19. E 95013

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Overdose of methyprylon and barbiturate

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

4014 W. Rogers Avenue

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY 11-15 or
(APPROX.) 11-16-68 ? m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Took overdose

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☒Homicide ☐Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 17, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/18/68

24C. NAME of CEMETERY or CREMATORY

Cherry Aharas Ched

24D. LOCATION (City, town, or county)

Randallstown

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

NOV 20 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

Sylvan S. Lewis & Son 9610 Rustington Rd

ADDRESS

1/6/69 - Correction form from funeral director.

AB.

W - 155

68-11636

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11636

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MELVIN L. WOPPMAN, SR.

2. DATE AND HOUR OF DEATH

11-15-68

6:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNIVERSITY OF MARYLAND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD.

BALTIMORE

C. CITY OR TOWN

ROSEDALE

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

7216 PULASKI HIGHWAY #21237.

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

2-23-20

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

RESTAURANT OWNER

11. BIRTHPLACE (State or foreign country)

MD. BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY L. WOPPMAN

14. MOTHER'S MAIDEN NAME

ANNA M. WOPPMAN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

W.W. II

16. SOCIAL
SECURITY NO.

214-12-9135

17. INFORMANT

ANNA E. WOPPMAN

ADDRESS

7216 PULASKI HIGHWAY
BALTO., 21237, MD.

18.

571.9

I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

GI HEMORRHAGE

GASTRIC ULCER

(B) DUE TO, OR AS A CONSEQUENCE OF:

ESOPHAGEAL VARICES

(C) DUE TO, OR AS A CONSEQUENCE OF:

CIRRHOSIS

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

12 hrs.

MEDICAL CERTIFICATION

581.0

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MYOCARDIAL ISCHEMIA

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/12 1968 to 11/15 1968,
that (I) (we) lost saw the deceased alive on 11/15 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jean M. Jackson, M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11/15/68

23C. PHYSICIAN'S
NAME (Type)

JEAN M. JACKSON, M.D.

23D. ADDRESS

University of Maryland Hospital
22 S. Greene St. Baltimore, Md. 2120124A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

11-19-68

24C. NAME OF CEMETERY or CREMATORY

OAK LAWN CEM

24D. LOCATION

7225 EASTERN BLVD BALTO., CO., MD.

25A. DATE REC'D BY HEALTH DEPT.

NOV 20 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

Charles L. Jolley

ADDRESS

901 S. CONKLIN
BALTO., 21223

FUNERAL DIRECTOR: IMPORTANT

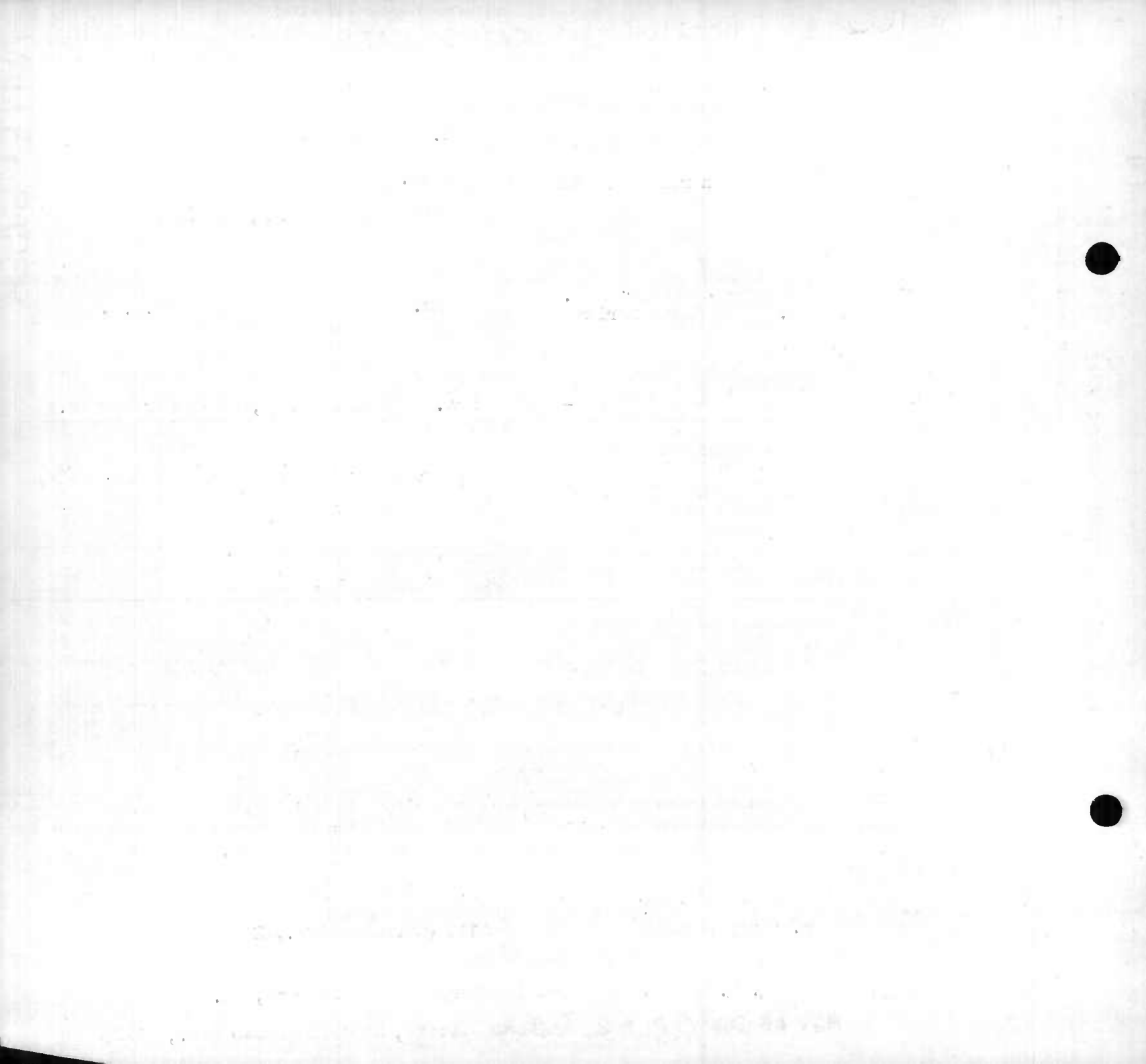
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11637
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Michael Duffy		11-19-68 10:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital			A. STATE Md. B. COUNTY Balto Co 53-00		
C. CITY OR TOWN Balto.			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 902 Vanderwood Road, Westview					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-02	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supt.		10B. KIND OF BUSINESS OR INDUSTRY Isthiman Co. State Marine		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Michael Duffy		14. MOTHER'S MAIDEN NAME Cecilia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 088-05-6128		17. INFORMANT Mrs. Catherine Duffy, 902 Vanderwood Rd.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
19. DATE OF OPERATION 0			20A. AUTOPSY? (Yes or No) No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Apr. 24, 1954 to Nov. 19, 1968, that (I) (we) last saw the deceased alive on Nov. 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry L. Knipp, MD			23B. DATE SIGNED 11-19-68		
23C. PHYSICIAN'S NAME (Type) Dr. Harry L Knipp			23D. ADDRESS 4116 Edmondson Ave., 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Md.		24E. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229			
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR Robert E. Fairburn		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229	



CERTIFICATE OF DEATH

REG. NO.

68-11638

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GRACEY, Elizabeth (LIZZIE)

2. DATE AND HOUR OF DEATH

11/18/68

11:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY MAPS?

YES ☒NO ☐

E. STREET AND NUMBER

21224
4940 Eastern Avenue, Baltimore City Hospitals

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2-26-1892

9. AGE (In years
lost birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEKEEPER

10B. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WM. R. GRACEY

14. MOTHER'S MAIDEN NAME

ELIZABETH EBLE

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE 11/18/68 Aspiration
DUE TO, OR AS A CONSEQUENCE OF:(B) 21 Hypertension 2° to Diabetes Mellitus
DUE TO, OR AS A CONSEQUENCE OF:

(C) 31 Stress Ulcer 41 Septicemia

260X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

31 A/O Intracerebral Bleed

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-9-19 63 to 11-18-19 68,
that (I) (we) last saw the deceased alive on 11-18-19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11-18-1968

23C. PHYSICIAN'S
NAME (Type)

Paul N. Kalkut

23D. ADDRESS

4940 Eastern Avenue 21224

DEGREE

Baltimore City Hospitals, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

11-21-68

24C. NAME OF CEMETERY or CREMATORY

LOUDON PARK CEM.

24D. LOCATION

(City, town, or county)

BALTO., MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 20 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

Gentle Miller - 2334 Jefferson St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11639 CERTIFICATE OF DEATH

REG. NO.

68-11639

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mr. Dennis Krotek		2. DATE AND HOUR OF DEATH 11-19-68 4-10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY 1-05	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital 35 Baltimore Maryland				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2205 E Pratt Street	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-18-94	9. AGE (In years lost birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10B. KIND OF BUSINESS OR INDUSTRY Janitor		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME Not known				12. CITIZEN OF WHAT COUNTRY? Russian	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				14. MOTHER'S MAIDEN NAME Not known	
16. SOCIAL SECURITY NO. 213-895-24				17. INFORMANT Mr Frank Rachuk & chart	
				ADDRESS 2205 E Pratt Street	
18. 412.31 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebro-vascular Accident cerebral embolism	
				(B) Arterio Sclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: And Auricular Fibrillation	
				(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.0 II					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) noon		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None	
22. I certify that (I) (this hospital) attended the deceased from 11-18-1968 to 11-19-1968 , that (I) (we) last saw the deceased alive on 11-19-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 11-19-68	
23C. PHYSICIAN'S NAME (Type) DR. A.E. SUBONG, JR				23D. ADDRESS Church Home & Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE NOV 22 1968		24C. NAME OF CEMETERY OR CREMATORY HOLY TRINITY CEMETERY	
				24D. LOCATION (City, town, or county) (State) ELK RIDGE MD	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR THE DIPPEL BROS INC 1800 E LOMBARD ST	

1000 1000 1000

11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11640

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11640

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Luther Hicks</i>		2. DATE AND HOUR OF DEATH <i>11/18/68</i> 8 ⁶² A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>91 Montebello State Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balt. City</i>		
			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>2458 Terra Firma Rd.</i>		
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-13-09</i>	9. AGE (In years lost birthday) <i>59</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe fitter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Beth Steel</i>		11. BIRTHPLACE (State or foreign country) <i>Va. Bedford Co.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Lemon Hicks</i>		14. MOTHER'S MAIDEN NAME <i>Saline Shitem</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-07-6382</i>		17. INFORMANT <i>Mrs. Virginia Hicks</i>	
				ADDRESS <i>2458 Terra Firma</i>	
18. <i>465X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <i>pulmonary embolus</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
19. <i>465X II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Carcinomatosis - pulmonary?</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>no</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Nov 20</i> 19 <i>68</i> to <i>Nov 18</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Nov 18</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>R. Anderson</i> M.D. DEGREE				23B. DATE SIGNED <i>11/18/68</i>	
23C. PHYSICIAN'S NAME (Type) Richard Anderson, M.D.				23D. ADDRESS Montebello State Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-21-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Park</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. DATE REC'D. BY HEALTH DEPT. NOV 20 1968			
25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Morton E. Dgett F.H.</i>			
25D. ADDRESS <i>1701 Laurens St.</i>					

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES H. WATKINS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 8, 1968		Hour 9:37 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOPKINS HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 8, 1968		Hour 9:37 A.M.
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH NOV 11, 1915		10. AGE (In years last birthday) 52		11. BIRTHPLACE (State or foreign country) ANDERSON, S.C.
12. CITIZEN OF USA.		13. FATHER'S NAME GEORGE WATKINS		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TECH MOTOR OPER.
15. MOTHER'S MAIDEN NAME JULIA SKY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES		17. SOCIAL SECURITY NO. 298-18-7401
18. INFORMANT ELIMABETH GREEN		19. ADDRESS 1926 E 31st St		

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hanging		2. CAUSE OF DEATH Hanging		3. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 9774X		5. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) HANGING		6. DUE TO, OR AS A CONSEQUENCE OF:	
7. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 9774X		8. DUE TO, OR AS A CONSEQUENCE OF:		9. DUE TO, OR AS A CONSEQUENCE OF:	
10. DATE OF OPERATION NOV 8, 1968		11. CONDITION FOR WHICH OPERATION WAS PERFORMED ???		12. AUTOPSY? (Yes or No) no	
13. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		14. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		15. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2304 E. Oliver Street	
16. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Nov. 8, 1968 ???		17. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		18. HOW DID INJURY OCCUR? Hanged himself	
19. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
20. ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		21. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED November 8, 1968	
23. EXAMINER'S NAME (Type)		24. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		25. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
26. BURIAL CREMATION, REMOVAL (Specify) BURIAL		27. DATE 11/10/68		28. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL	
29. DATE REC'D BY HEALTH DEPT. NOV 20 1968		30. NAME OF REGISTRAR Robert E. Jenkins		31. FUNERAL DIRECTOR DONALD E. GLOVER	
32. ADDRESS 5500 REEDER RD, AVE BRTM		33. ADDRESS 1701 N. PATTERSON		34. ADDRESS	

Nov 11, 1915
Anderson, S. C. U.S.A. George W. Atkins
The more often examining John 24
222-194 Empirical Green 1902-1915

MAIL INDEX

Book 11/10/15
George W. Atkins
Nov 11, 1915

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

68-11642

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Emily Weed Fauntleroy</i>		2. DATE AND HOUR OF DEATH <i>Nov 17/68 5:15 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Maryland</i> B. COUNTY <i>15-01</i>	
		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>609 Gold Street</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/28/28</i>	9. AGE (In years last birthday) <i>40</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>US</i>		13. FATHER'S NAME <i>Sam Fauntleroy</i>		14. MOTHER'S MAIDEN NAME <i>Margaret</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Charles Samorodina M.D. Univ. Hosp</i>	
18. <i>303.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Shock - etiology?</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hepatic failure, chronic alcoholism</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>UTI, subcutaneous abscess</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>—</i>			
(C) DUE TO, OR AS A CONSEQUENCE OF: <i>—</i>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>UTI, subcutaneous abscess</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>	
21D. TIME OF INJURY (APPROX.) <i>—</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat. While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>	
22. I certify that (I) (<i>this hospital</i>) attended the deceased from <i>11/9/68</i> 19 <i>68</i> to <i>11/17</i> 19 <i>68</i> , that (I) (<i>was</i>) last saw the deceased alive on <i>11/17</i> 19 <i>68</i> and that in (my) (<i>—</i>) opinion death occurred on the date and hour and from the causes stated above. (I) (<i>did</i>) (<i>did not</i>) view the body after death.					
23A. SIGNATURE <i>Charles Samorodina M.D.</i>				23B. DATE SIGNED <i>11/17</i>	
23C. PHYSICIAN'S NAME (Type) <i>Charles Samorodina M.D.</i>		23D. ADDRESS <i>University</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>11-23-68</i>	24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 20 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>—</i>	

University Hospital

From: [illegible]

To: [illegible]

Re: [illegible]

[illegible]

5

1000
1000
1000

* 10/1/58

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10/1/58

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10/1/58

10/1/58

NTI, [illegible]

10/1/58

10/1/58

Charles [illegible]
University

R-163 1

68-11643 CERTIFICATE OF DEATH

REG. NO. 68-11643

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Herbert Carlton Roberts		11-18-68 2:30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 3900 N. Charles Street				Maryland	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				3900 N. Charles Street	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years lost birthday)
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7-27-1884	84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Executive -Owner		Packing House		Baltimore, Maryland	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
William Henry Roberts				U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		214-03-1108B		Mrs. Herbert C. Roberts Same	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
185X I Carcinoma of prostate with metastases many years					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
197X II Arteriosclerotic cardiovascular disease many years					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 1956 to Nov 18 1968, that (I) (we) last saw the deceased alive on Nov 17 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Alfred G. Ossman, Jr.				11-19-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Alfred G. Ossman, Jr.				1101 St. Paul Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11-20-68		Druid Ridge Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 20 1968		Robert E. Jenkins		Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

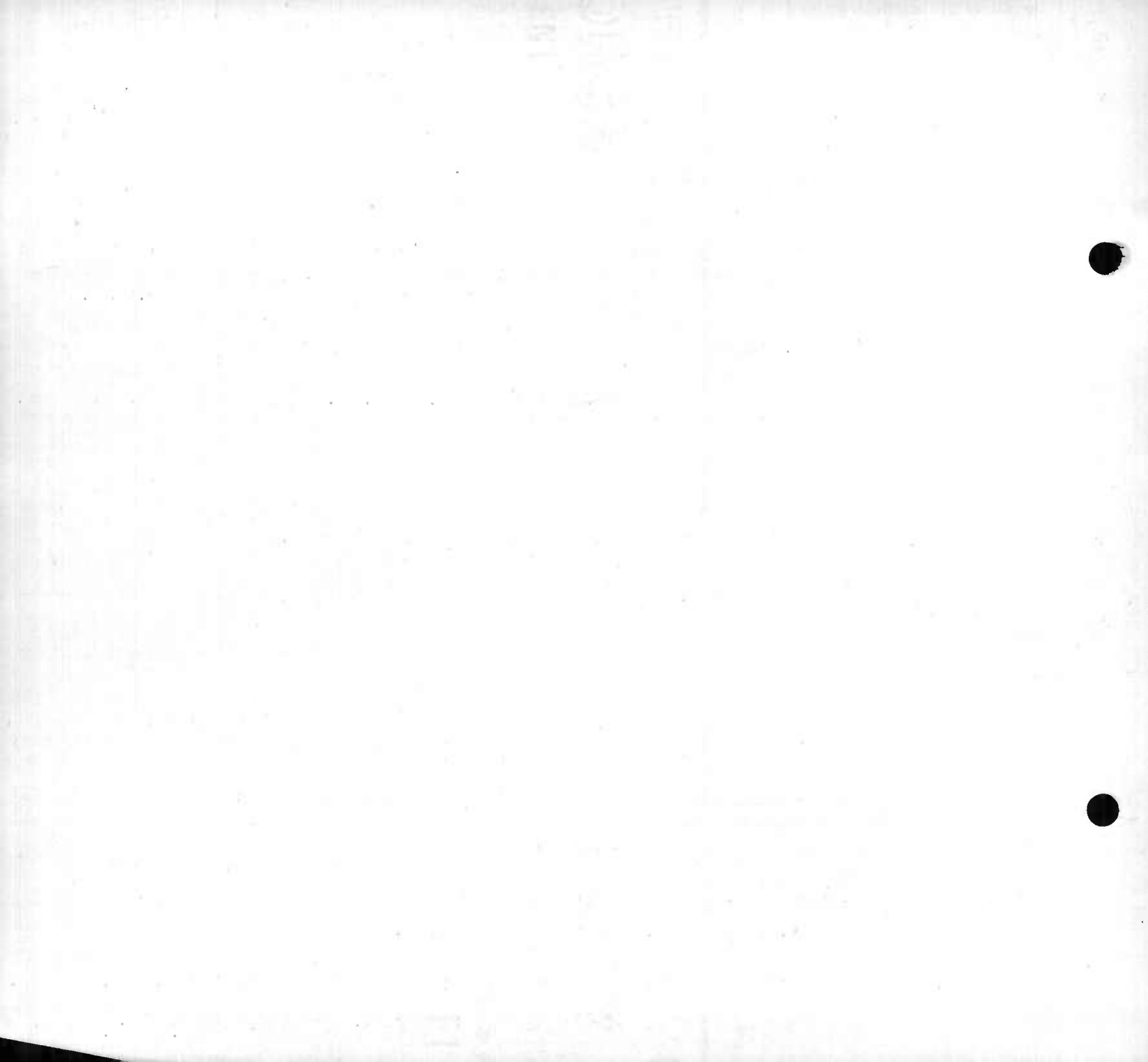
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-1001

BALTIMORE CITY HEALTH DEPARTMENT 68-11644 CERTIFICATE OF DEATH

REG. NO. 68-11644

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Evelyn Soper Roby		2. DATE AND HOUR OF DEATH 11-18-68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Marylander Apartments		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-02		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 3501 St. Paul Street			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-1882	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William T. Soper			
14. MOTHER'S MAIDEN NAME Katherine Schwartz		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 220-44-0117		17. INFORMANT Mr. Wm. J. Soper			
ADDRESS Marylander Apts.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Occlusion (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min. 10 yrs	
19. DATE OF OPERATION 4-20-1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 29 1943 to Nov. 18 1968, that (I) (we) last saw the deceased alive on Oct. 15 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE C. Holmes Boyd		DEGREE Dr. Holmes C. Boyd		23B. DATE SIGNED 11/19/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 24 E. Eager Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-21-68		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 210			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11645	
68-11645		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Myrtle M. Murphy	
2. DATE AND HOUR OF DEATH Nov. 18, 1968		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 500 Harwood Ave.	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 500 Harwood Ave.	
6. DATE OF BIRTH 10/28/1898		7. AGE (In years last birthday) 70	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. IF UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic-Retired		10B. KIND OF BUSINESS OR INDUSTRY Balto. City Schools	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Geidt		14. MOTHER'S MAIDEN NAME Catherine Eckes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-20-6038	
17. INFORMANT Mrs. William Harris		ADDRESS 721 Hollen Rd.	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiac vascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6+ yrs	
19. 443X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arterial hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6+ yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 25 1968 to Nov 18 1968 , that (I) (we) last saw the deceased alive on Nov 14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Frederick J. Vollmer		23B. DATE SIGNED Nov 19, 1968	
23C. PHYSICIAN'S NAME (Type) Dr. Frederick J. Vollmer		23D. ADDRESS 6100 York Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/21/68	
24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Parkville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11646

BIRTH NO. 68-17996

REG. NO.

1. NAME OF DECEASED
(Type or Print)

MONICA LOWDER

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

11

17

68

9:50 a. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CERTIFICATE AMENDED

Maryland General Hospital 12-17-68

3. DATE
PRONOUNCED DEAD

November 17, 1968

9:50 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

6. SEX

7. RACE

B. MARRIED ☐ NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Female

Colored

WIDOWED ☐DIVORCED ☐

Balto.

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years lost birthday)

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

Sept 17-68

6 wks.

E. STREET AND NUMBER

11 W. Biddle St.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Lowder

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Katherine Briscoe

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Charles Lowder 11 W. Biddle St

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Craniocerebral injuries

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E 936.9 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

2

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

11 W. Biddle St.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

?

?

68

?

m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Unknown

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ ~~Other~~ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 18, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-19-68

24C. NAME of CEMETERY or CREMATORY

Mt. Airy Cemetery Balto

24D. LOCATION

(City, town, or county)

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

NOV 20 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Rayner Sanders 217 E. Preston

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

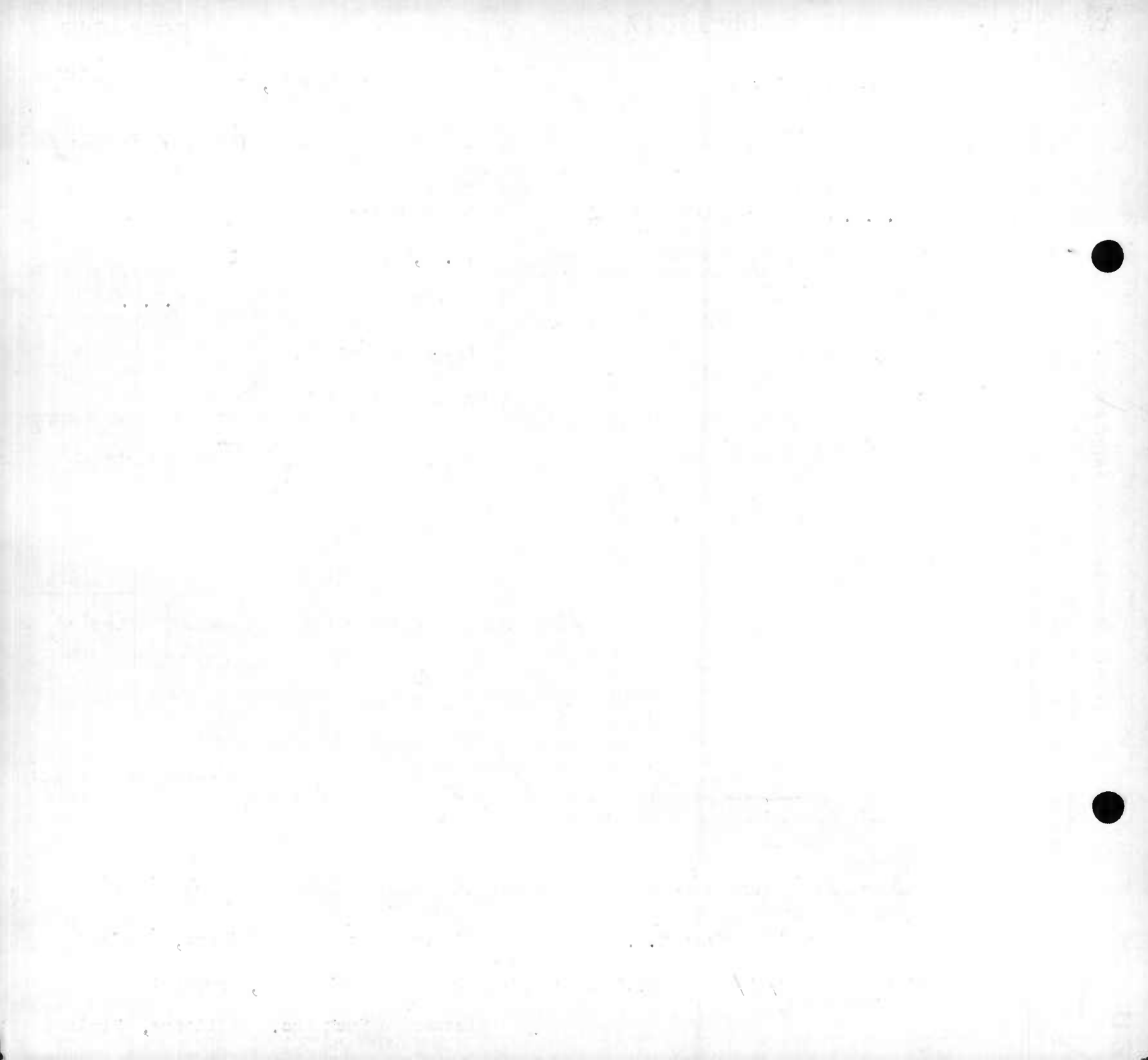
68-11647

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11647

BIRTH NO.		1. NAME OF DECEASED (Type or Print) James A Natale		2. DATE AND HOUR OF DEATH November 18, 1968 <i>11:20 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 44 99 D.O.A. Union Memorial Hospital		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 3508 Mary Ave	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1896	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plaster		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Pedro Natale		14. MOTHER'S MAIDEN NAME Laura Spigoni	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Theresa Natale Same	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. Recurrent peptic ulcer & hemorrhage 10 yrs			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/15 1963 to 11/18 1968 , that (I) (we) last saw the deceased alive on 8/10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel Morrison		DEGREE <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/19/68	
23C. PHYSICIAN'S NAME (Type) Samuel Morrison M.D.		DEGREE 11 East Chase St Baltimore, Maryland		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/22/68	24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Pk		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 19 1968		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11648

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11648

BIRTH NO.		1. NAME OF DECEASED (Type or Print) OLIVE G. SMITH		2. DATE AND HOUR OF DEATH November 18, 1968. 2:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1058 TUNBRIDGE ROAD		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1058 TUNBRIDGE ROAD	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1911	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Mildred Brackett		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-01-2399		17. INFORMANT ADDRESS MR. PETER SMITH (SAME) E	
18. 199.0 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CARCINOMATOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 19 67 to NOVEMBER 18 19 68 , that (I) (we) last saw the deceased alive on NOVEMBER 18 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert E. May</i>				23B. DATE SIGNED NOV 19, 1968	
23C. PHYSICIAN'S NAME (Type) Robert May M.D.		23D. ADDRESS 5662 The Alameda Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/20/68		24C. NAME OF CEMETERY or CREMATORY Moreland Em. Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE RECEIVED BY HEALTH DEPT. NOV 20 1968			
25B. NAME OF REGISTRAR <i>Robert E. May</i>		25C. FUNERAL DIRECTOR ADDRESS LEONARD J. RUCK, INC. BALTO. MD. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11649 CERTIFICATE OF DEATH

REG. NO. 68-11649

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Laura V Schenning		2. DATE AND HOUR OF DEATH 11-19-68 10 15/A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 27-07		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		E. STREET AND NUMBER 6816 Harford Road		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-20-91	9. AGE (In years last birthday) 77	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Green		14. MOTHER'S MAIDEN NAME Elizabeth Michael		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-9190		17. INFORMANT ADDRESS Mr George Schenning Same	
18. 412, 41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Anteroseclerotic Cardiovascular Dis.		CAUSE OF DEATH (A) IMMEDIATE DUE TO, OR AS A CONSEQUENCE OF: Anteroseclerotic Cardiovascular Dis.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, 422, 11 Lung mass		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422, 11					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 10-25 19 68 to 11-19 19 68 , that (H) (we) last saw the deceased alive on 11-18 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen Goldgerger MD		23B. DATE SIGNED 11-19-68		23C. PHYSICIAN'S NAME (Type) Stephen Goldgerger	
23D. ADDRESS 2511-D Steele Rd Baltimore		23E. NAME OF CEMETERY or CREMATORY Parkwood		23F. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/68		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. DATE REC'D BY NOV 28 1968		24E. NAME OF REGISTRAR Robert E. Farkner		24F. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc Baltimore, Maryland	

1944-1945

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FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				REG. NO.	
68-11650				68-11650	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
W. Elsie E. Ewell				11/17/68 1:35 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
44 Union Memorial Hosp.				Md. Baltimore	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				333 N. Charles St.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W		11/06/98	70	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
SALES LADY			Maryland		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Edward E. Ziegler			WILKENS, MARY E		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			216-32-8284		21230
18. 199.0 I			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Concinomatosis		
ANTECEDENT CAUSES			(B) Metastatic Carcinoma of Liver		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
199.2 II					C.S.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (This hospital) attended the deceased from Oct 27 1968 to Nov 17 1968, that (I) (we) last saw the deceased alive on Nov 17 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Charles Robert Gerber M.D.				11/17/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Charles Robert Gerber, MD				Union Memorial Hospital Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	11-21-68	Glen Haven Memorial Cemetery	Glen Burnie A. A. Md.		
25A. DATE REC'D	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
NOV 20 1968	Robert E. Gerber, MD	Howard H. Hubbard 4107 Wilkens Ave. 21229			

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Salal Lay

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216-37-004

no

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11651 CERTIFICATE OF DEATH

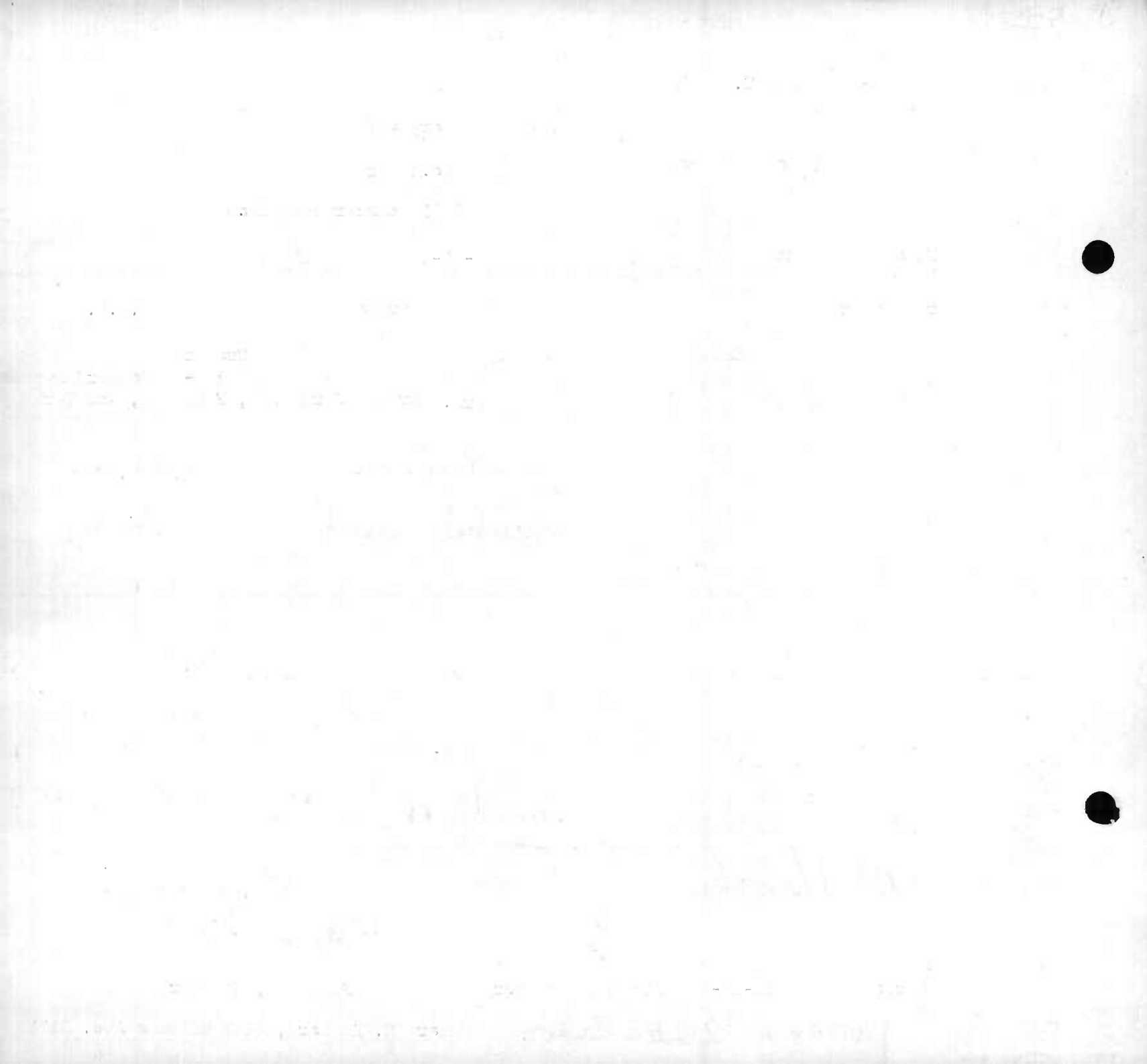
REG. NO. 68-2781
68-11651

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Norman Lee Brewer, SR.</u>		2. DATE AND HOUR OF DEATH <u>Nov 16 1968</u> <u>12:45</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>21230</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital of Maryland</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2807 Indiana Ave</u>		E. STREET AND NUMBER	
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-87</u>	9. AGE (In years lost birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. Transit Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>William G. Brewer</u>		14. MOTHER'S MAIDEN NAME <u>Georgia Thompson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-9926A</u>		17. INFORMANT <u>Mr. Norman L. Brewer, Jr. 2807 Indiana St.</u>	
18. <u>5-4-0-01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>renal shut down</u> (B) <u>septicemia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ruptured cecum</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>72 hrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>5-5-0-1 II</u>					
19A. DATE OF OPERATION <u>Nov. 12 1968</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>NOV. 11 1968</u> to <u>NOV. 16 1968</u> that (I) (we) last saw the deceased alive on <u>NOV. 16 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Tracy Chung</u>		23B. DATE SIGNED <u>NOV 16 1968</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Elliott Fishel</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-19-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D <u>NOV 21 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Hubbard</u>	
25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11652</u>
BIRTH NO. <u>68-11652</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>GRACE T. JONES</u>		2. DATE AND HOUR OF DEATH <u>11-15-68</u> <u>11:30</u> <u>A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42</u> <u>Sinai Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-16</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4613 Reisterstown Road</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-1886</u>	9. AGE (In years last birthday) <u>82</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dressmaker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Leech</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>144-60 Sanford Avenue</u> <u>Mrs. Marilyn Jeremenko, Flushing, New York</u>
18. <u>470.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Amythmia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>420.1 II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>?</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> 19 <u>68</u> to <u>11/15</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>M. Horinstein</u>		23B. DATE SIGNED <u>11/15/68</u>		23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-18-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Flushing Cemetery</u>
24D. LOCATION <u>Flushing, New York</u>		24E. ADDRESS <u>Flushing, New York</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 20 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, MD</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>



FUNERAL DIRECTOR: IMPORTANT

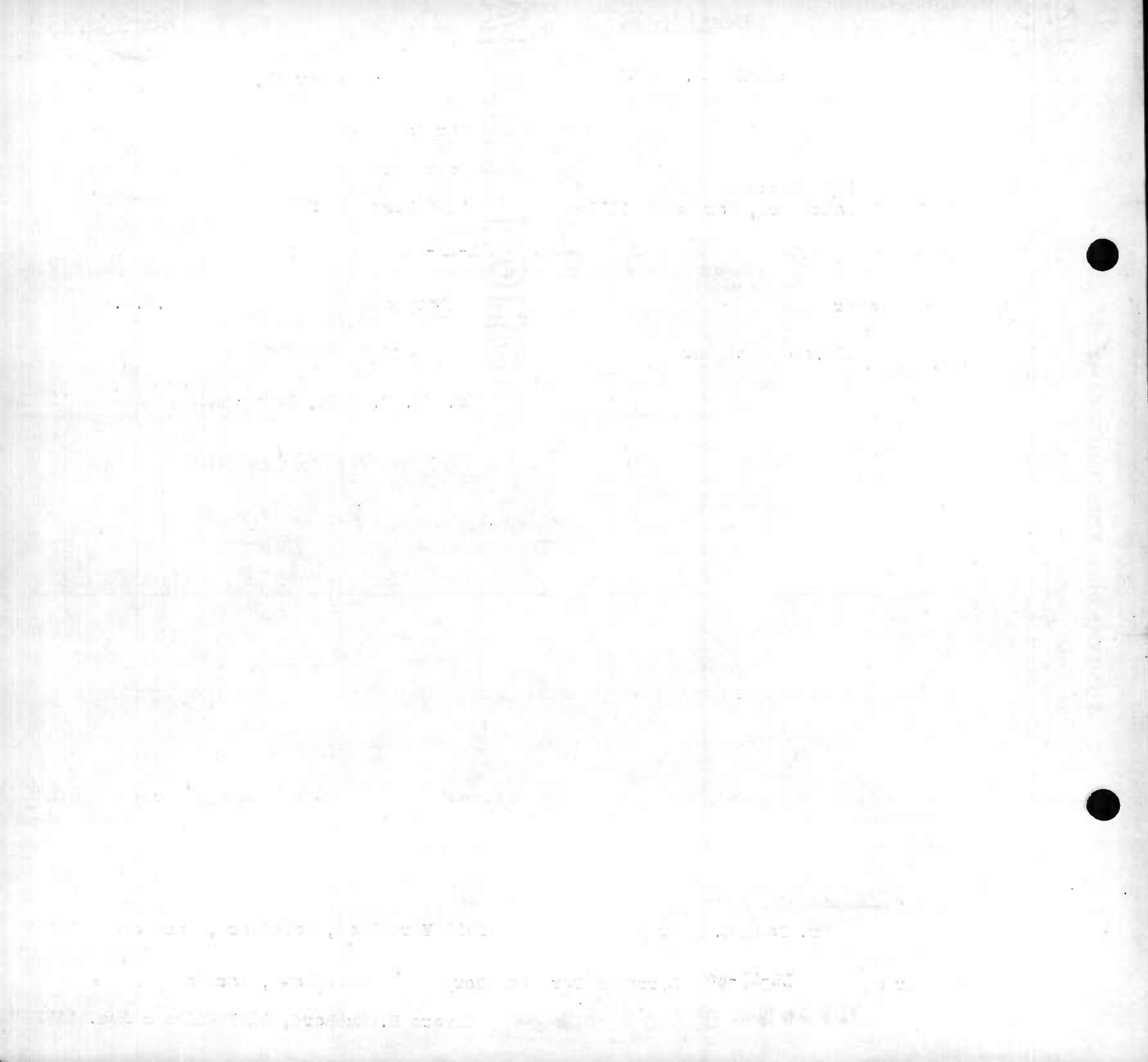
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11653

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

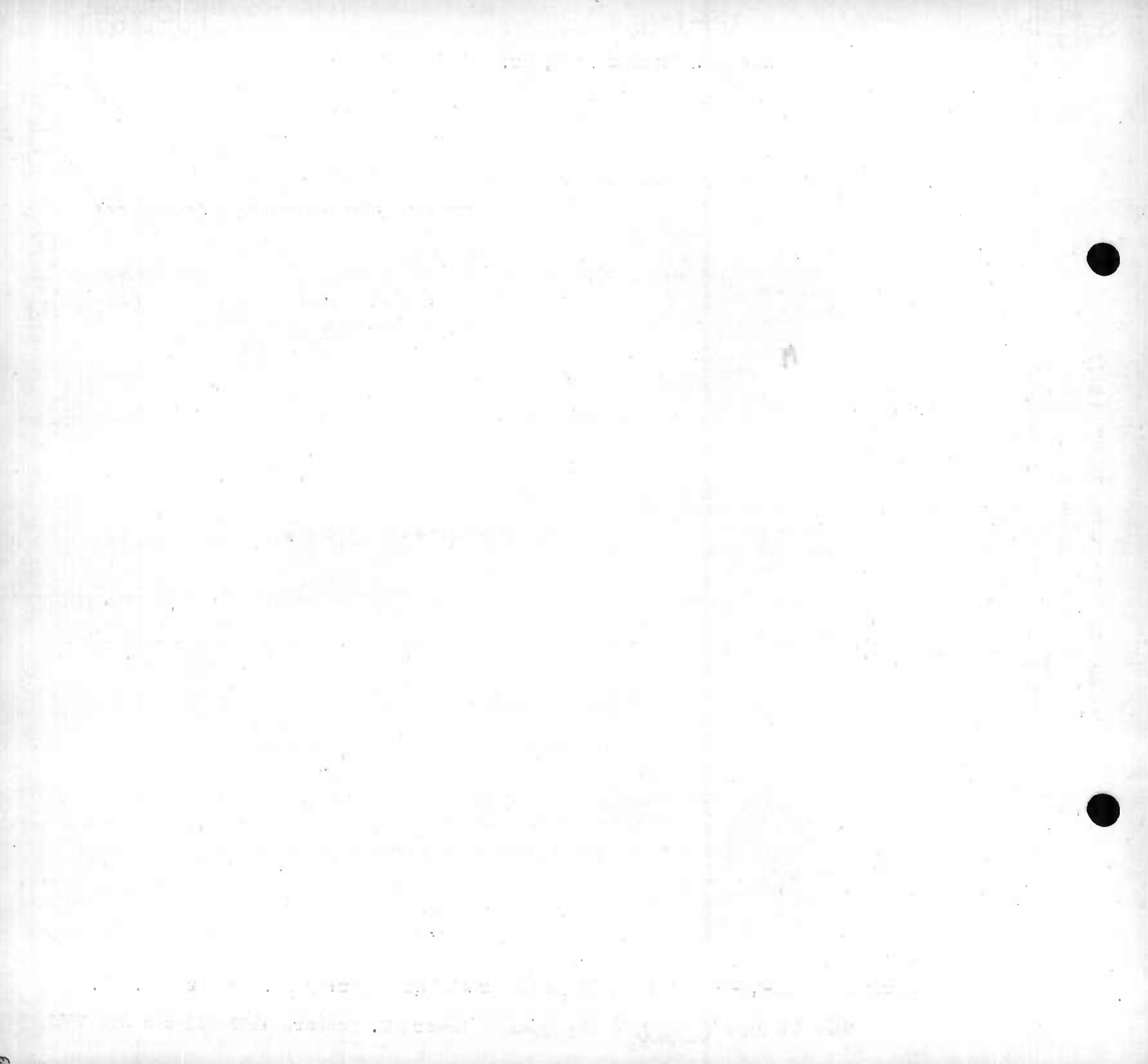
REG. NO. 68-11653

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		NAOMI A. BELT		November 17, 1968 9:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
2408 Westwood Avenue Baltimore, Maryland 21216				Maryland	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				2408 Westwood Avenue	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11-15-90	78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Homemaker			Maryland		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Zeigler			Agnes Hopkins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
					Mr. Ed. G. Belt, 2408 Westwood Avenue 21216
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Crowning Sclerosis</i>					
(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Anterior Myocardial Infarction</i>					
(C) <i>Congestive heart failure</i>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 1968 to Nov 18 1968, that (I) (we) last saw the deceased alive on Nov 18 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Dr. Paul M. Byerly</i>				11/18/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Paul M. Byerly				5820 York Road, Baltimore, Maryland 21212	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11-20-68		Lorraine Park Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Woodlawn, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 20 1968		Robert E. Hubbard		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11654
68-11654				CERTIFICATE OF DEATH
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <i>William S. Stachorowski, Sr.</i>		2. DATE AND HOUR OF DEATH <i>11-17-68</i> <i>2 A</i> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Balto Co</i> <i>53-00</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hosp.</i> <i>43</i>		C. CITY OR TOWN <i>Lansdowne</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>2933 Hammonds Ferry Rd</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-18-33</i>	9. AGE (In years lost birthday) <i>35</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>stevedor</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>US</i>		13. FATHER'S NAME <i>William Stachorowski</i>		
14. MOTHER'S MAIDEN NAME <i>Jda Lasek</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unkn.</i>		
16. SOCIAL SECURITY NO. —		17. INFORMANT <i>Admission Street</i>		
18. <i>394.0</i> I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <i>Mitral stenosis</i> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) <i>Rheumatic Heart dis.</i> DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) —		
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) <i>Yes</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —
22. I certify that (I) (this hospital) attended the deceased from <i>11-12</i> <i>1968</i> to <i>2 AM 11-17</i> <i>1968</i> , that (I) (we) last saw the deceased alive on <i>2 AM 11-17</i> <i>1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>C. G. Baumann</i> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11-17-68</i>
23C. PHYSICIAN'S NAME (Type) <i>C. G. BAUMANN</i> DEGREE		23D. ADDRESS <i>South Baltimore General Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>11-20-68</i>	24C. NAME OF CEMETERY or CREMATORY <i>Meadow Ridge Memorial Park</i>	24D. LOCATION (City, town, or county) (State) <i>Dorsey Rd. Howard Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 20 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>
				ADDRESS <i>4107 Wilkens Ave 21229</i>



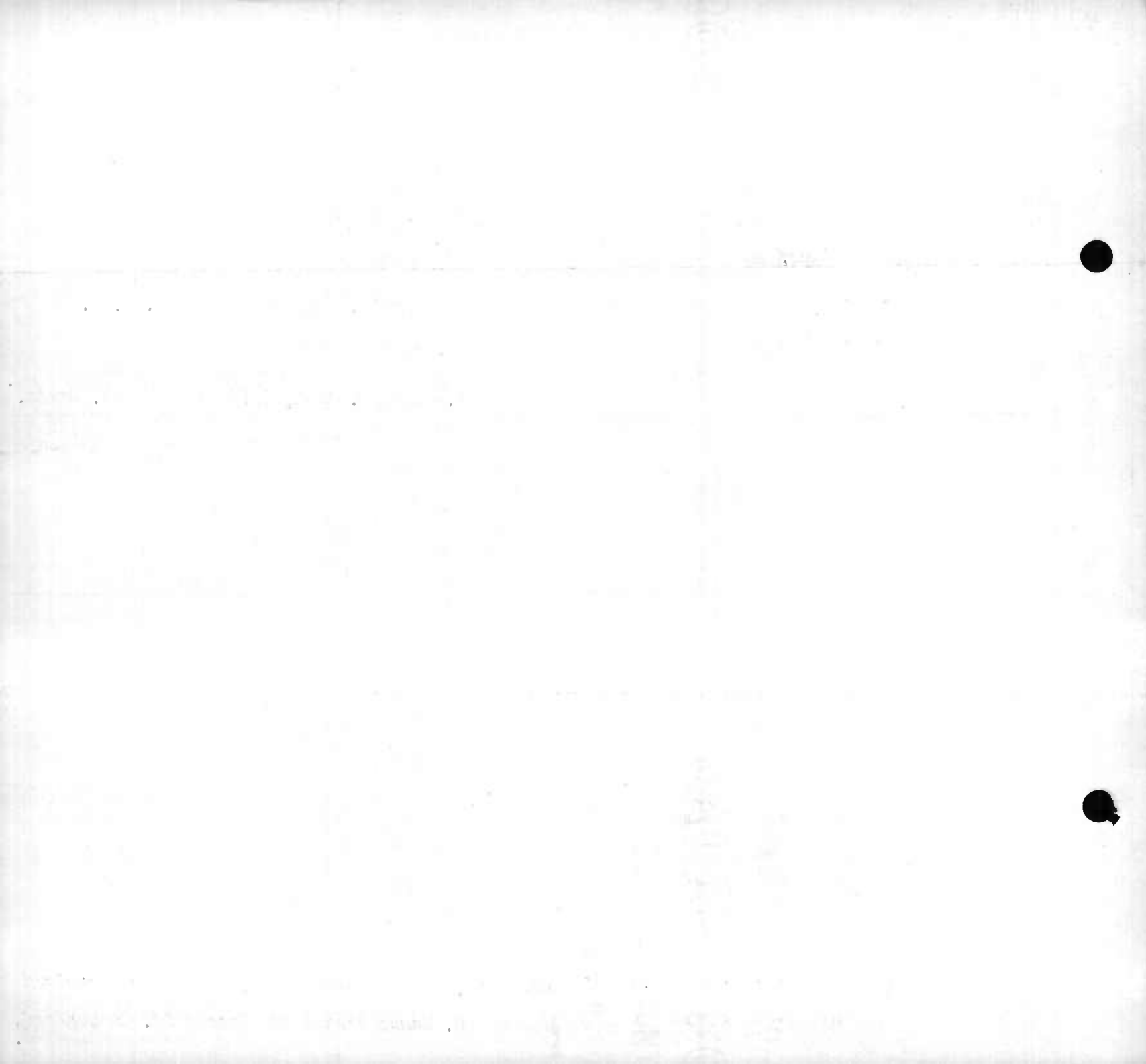
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11655 CERTIFICATE OF DEATH

REG. NO. 68-11655

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Leatha Wilson</u>		2. DATE AND HOUR OF DEATH <u>11/14/68</u> <u>9:46</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sina Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Md.</u> B. COUNTY	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>4017 Hayward Ave</u>					
5. SEX <u>F</u>	6. RACE <u>Cauc. 2</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/28/86</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife,</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Westernport, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Benjamin Arnold</u>		14. MOTHER'S MAIDEN NAME <u>Molly (unknown)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No,</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Ralph W. Acor, 4017 Hayward Ave. Balto. Md.</u>	
18. <u>4369 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CVA</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CVA</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
19. <u>331X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 15</u> 19 <u>68</u> to <u>Nov. 16</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov. 16</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Barton A. Cohen</u>		23B. DATE SIGNED <u>11/14/68</u>			
23C. PHYSICIAN'S NAME (Type) <u>Barton A. Cohen</u>		23D. ADDRESS <u>Sina Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/19/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Rose Hill Cemetery,</u>	
24D. LOCATION (City, town, or county) (State) <u>Cumberland, Allegany Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 20 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>H. Wayne George</u>	
25D. ADDRESS <u>202 Greene St. Cumberland, Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

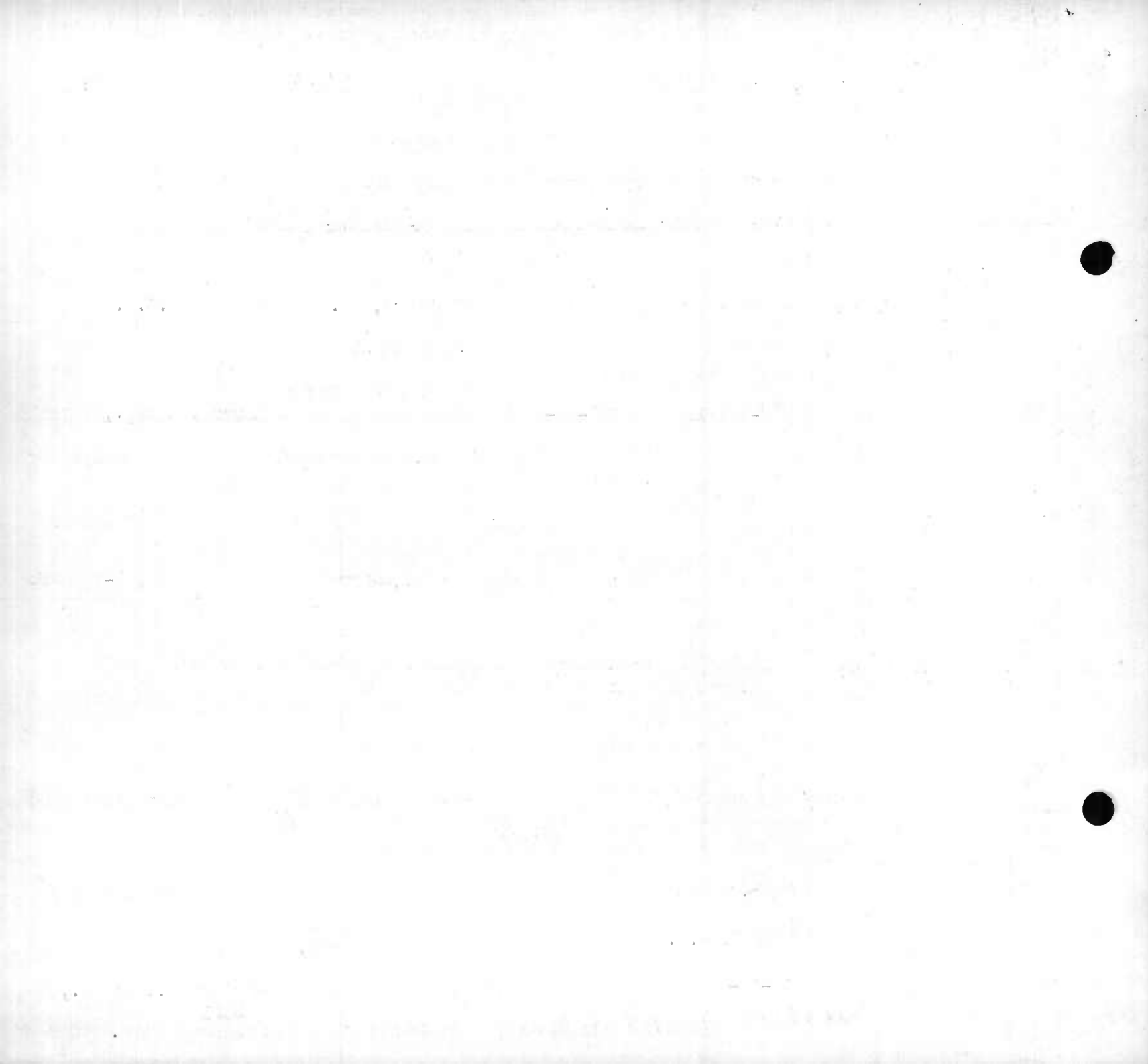
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11656 CERTIFICATE OF DEATH

REG. NO.

68-11656

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LANTZ, Leon William		2. DATE AND HOUR OF DEATH 11/17/68 8:05 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		E. STREET AND NUMBER 2905 St Paul Street			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/97	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY House painting		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Leon Lantz		14. MOTHER'S MAIDEN NAME Sarah Gantt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11/6/17-11/7/19		16. SOCIAL SECURITY NO. 218-05-3663		17. INFORMANT VA Hospital Records 3900 Loch Raven Boulevard, Balto., Md 21218	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Terminal pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Uremia Carcinoma of Bladder		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Terminal pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Uremia (C) Carcinoma of Bladder		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 months ? 1-2 years	
18/11/0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 10/31/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bilateral ureterocutaneous transplantation		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (✓) (this hospital) attended the deceased from September 3rd 19 68 to November 17th 19 68 , that (✓) (we) last saw the deceased alive on November 17th 19 68 and that in (✓) (our) opinion death occurred on the date and hour and from the causes stated above. (✓) (We) (did) (did not) view the body after death.					
23A. SIGNATURE N Bayadi		23B. DATE SIGNED 11/18/68		23C. PHYSICIAN'S NAME (Type) N BAYADI, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-21-68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21218		24E. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218		24F. ADDRESS 5500 Frederick Rd., Balto., Md	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Wm Johnson	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11657

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11657

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GEORGE E. KANE		2. DATE AND HOUR OF DEATH November 16, 1968 10 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Essex 21221 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 211 Margaret Avenue	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1911		9. AGE (In years last birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Thomas Kane	
14. MOTHER'S MAIDEN NAME Estella Moorelock				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 213 09 7071				17. INFORMANT Helen Kane Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/10.9 I Coronary Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH same day					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II arteriosclerosis heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several yrs					
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0 20A. AUTOPSY? (Yes or No) 0 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 0 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 0 21D. TIME OF INJURY (Approx.) 0 21E. HOW DID INJURY OCCUR? 0					
22. I certify that (I) (this hospital) attended the deceased from 2/20 1968 to 11/17 1968 , that (I) (we) lost saw the deceased alive on 10/22 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. BLATT, M.D. DEGREE				23B. DATE SIGNED 11/18/68	
23C. PHYSICIAN'S NAME (Type) J. BLATT, M.D. DEGREE				23D. ADDRESS Essex, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/20/68		24C. NAME OF CEMETERY or CREMATORY Holly Hill Memorial Gardens	
24D. LOCATION Baltimore Co., Md.		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR Bruzdzinski Funeral Home	
25D. ADDRESS 1407 Eastern Ave.					

1-1-1901

12-1-1901

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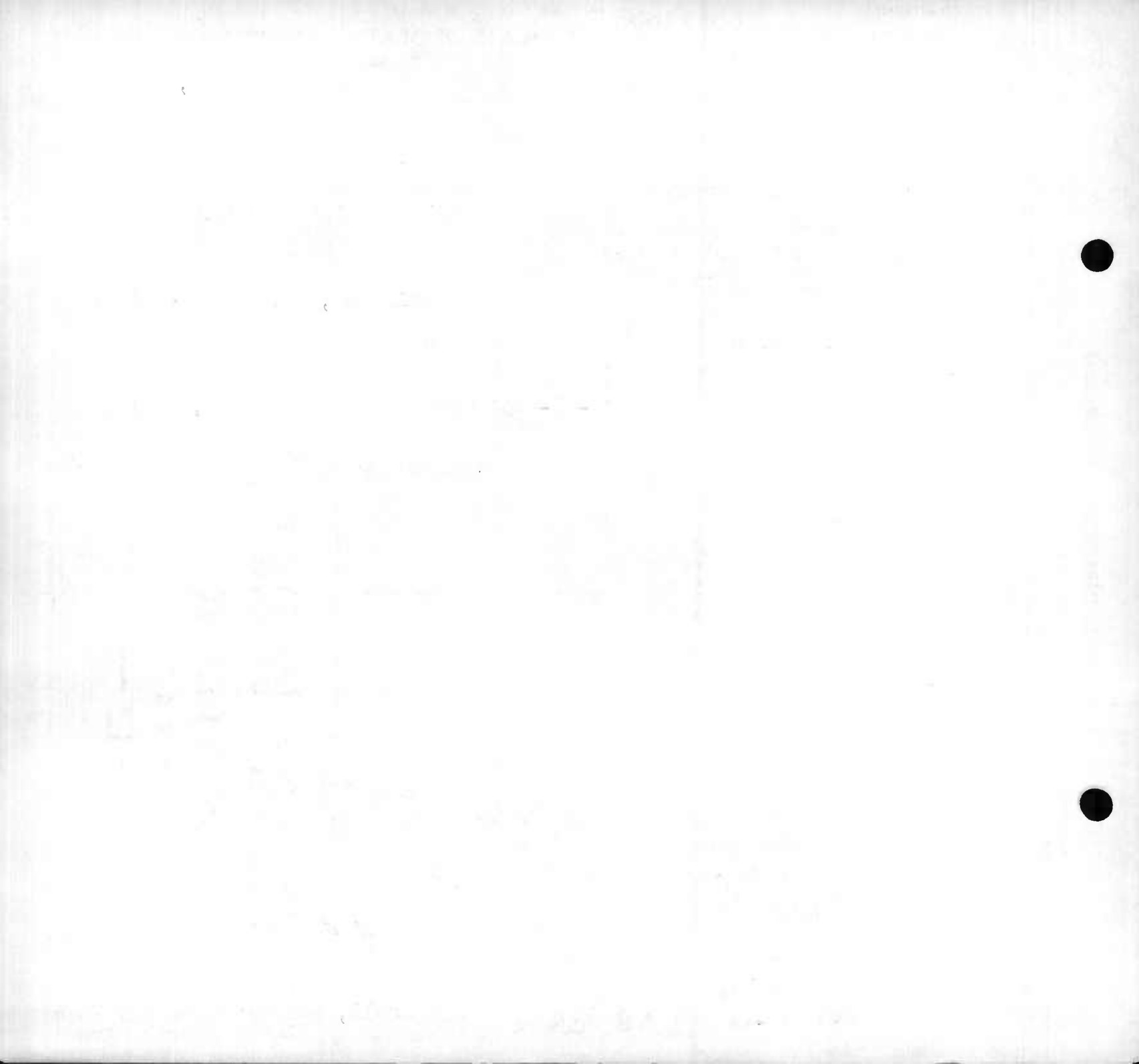
12-1-1901

12-1-1901

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
68-11658				68-11658		68-11658	
M.E. CASE NO.				M.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ELMER MASON				NOVEMBER 18, 1968			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 313 E 24th Street				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				313 E 24th Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
M	C	Married		69			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					Baltimore, Md		U S A
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Walter I Mason				Stacia			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
			216-01-0836		Mrs Bertha Lee Mason, same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		Carcinoma - Lung. 3 months	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
163X II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9/9 1968 to 11/18 1968, that (I) (we) last saw the deceased alive on 11/16/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
James S. Julian, M. D.						11/19/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JAMES S. JULIAN, M. D. 511 N. Schroeder St.				511 N. Schroeder St. Park, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. NAME OF CEMETERY or CREMATORY		24C. LOCATION (City, town, or county)		24D. LOCATION (State)	
Burial		Baltimore 23, Md.		Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 20 1968		Robert E. Feltz		I Carroll, Halstead Funeral Home		1206 W North Ave	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY HOWARD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 15, 1968 Hour 9:55 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 610 George Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 15, 1968 9:55 A.M.	
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH 11/23/		10. AGE (In years lost birthday) 56	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF U S A		13. FATHER'S NAME Samuel Foreman	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Florence Jeffery		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs Carrie Douglass, 851 George St	
19. 4/12/4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteiosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> November 15, 1968 DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/23/68	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks	
25C. FUNERAL DIRECTOR I Carroll, Halstead Funeral Home		ADDRESS 1206 W North Ave	

Robert W. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

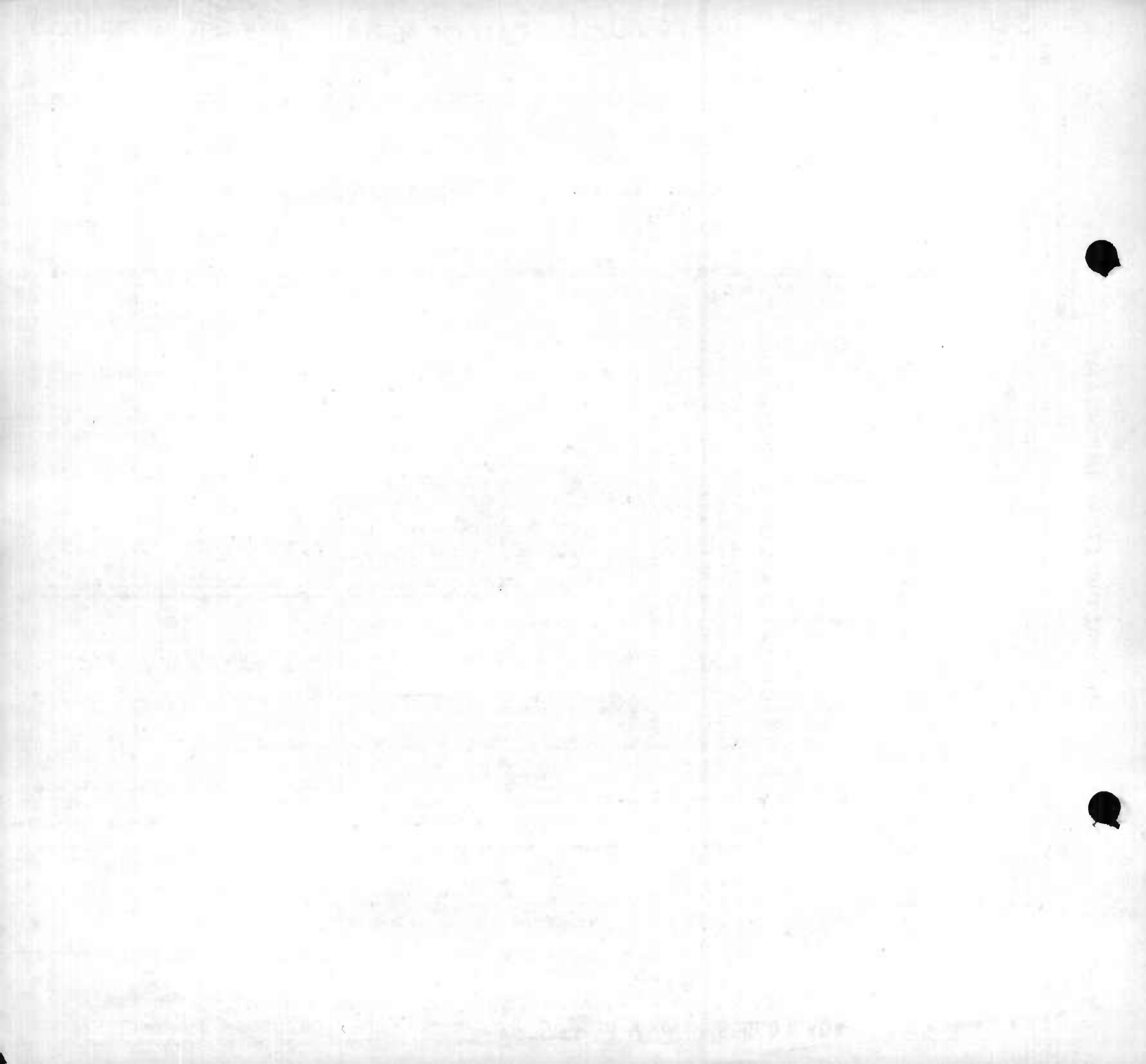
68-11660 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11660

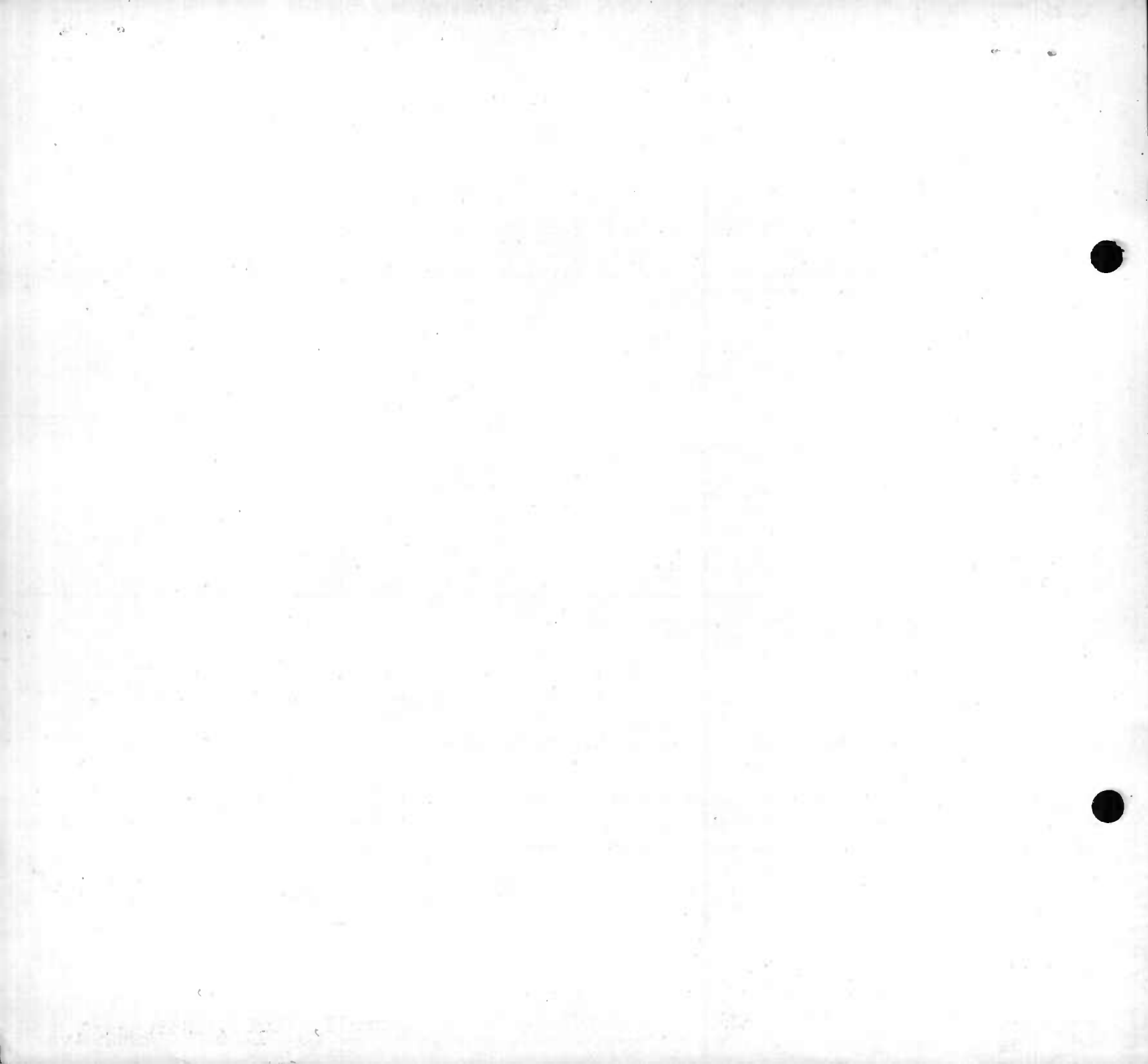
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Grace Smith		2. DATE AND HOUR OF DEATH Nov 17/68 12 45 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 11-02	
FULL NAME OF HOSPITAL OR INSTITUTION 90		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Midtown Home 808 St. Paul St. Balt, Md		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 10/14/89	
13. FATHER'S NAME John Collins		14. MOTHER'S MAIDEN NAME Sarah		9. AGE (In years lost birthday) 79	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214185461A		17. INFORMANT MRs Downs,	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Heart Failure DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular Failure Art CVD DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident Malnutrition		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 14 1968 to Nov 17 1968 , that (I) (we) last saw the deceased alive on Nov 17 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE William Applefezi				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) William Applefezi		23D. ADDRESS 6615 N. Kensington Rd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/21/68		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md					
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR I Carroll, Halstead Funeral Home	
				ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11661
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		McKNIGHT, COLLIE		11/18/68 10 30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
UNIV. OF MARYLAND HOSPITAL			MD. - 4-02		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			250 N. PEARL ST.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	NEGRO		1/3/15	53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		UNEMPLOYED		VA.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
BOB GOLDEN			FANNIE FORD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				CHART	
18. 577.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			CARDIO PULMONARY ARREST 1 NR		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			ASPIRATION - GASTRIC CONTENTS 1'15" MIN		
			(C) ? ACUTE PANCREATITIS		
			GET SEPSIS		
18. 587.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/18/68 19 68 to 11/18 19 68, that (I) (we) last saw the deceased alive on 11/18 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Michael J. Deegan, M.D.				11/18/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				UNIV. OF MD. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11/23/68		Mt. Auburn Cemetery	
				Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 20 1968		Robert E. Halstead		I Carroll, Halstead Funeral Home	
				1206 W North Ave	



1
68-11662
L-313

68-11662 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11662

BIRTH NO. 68-08322

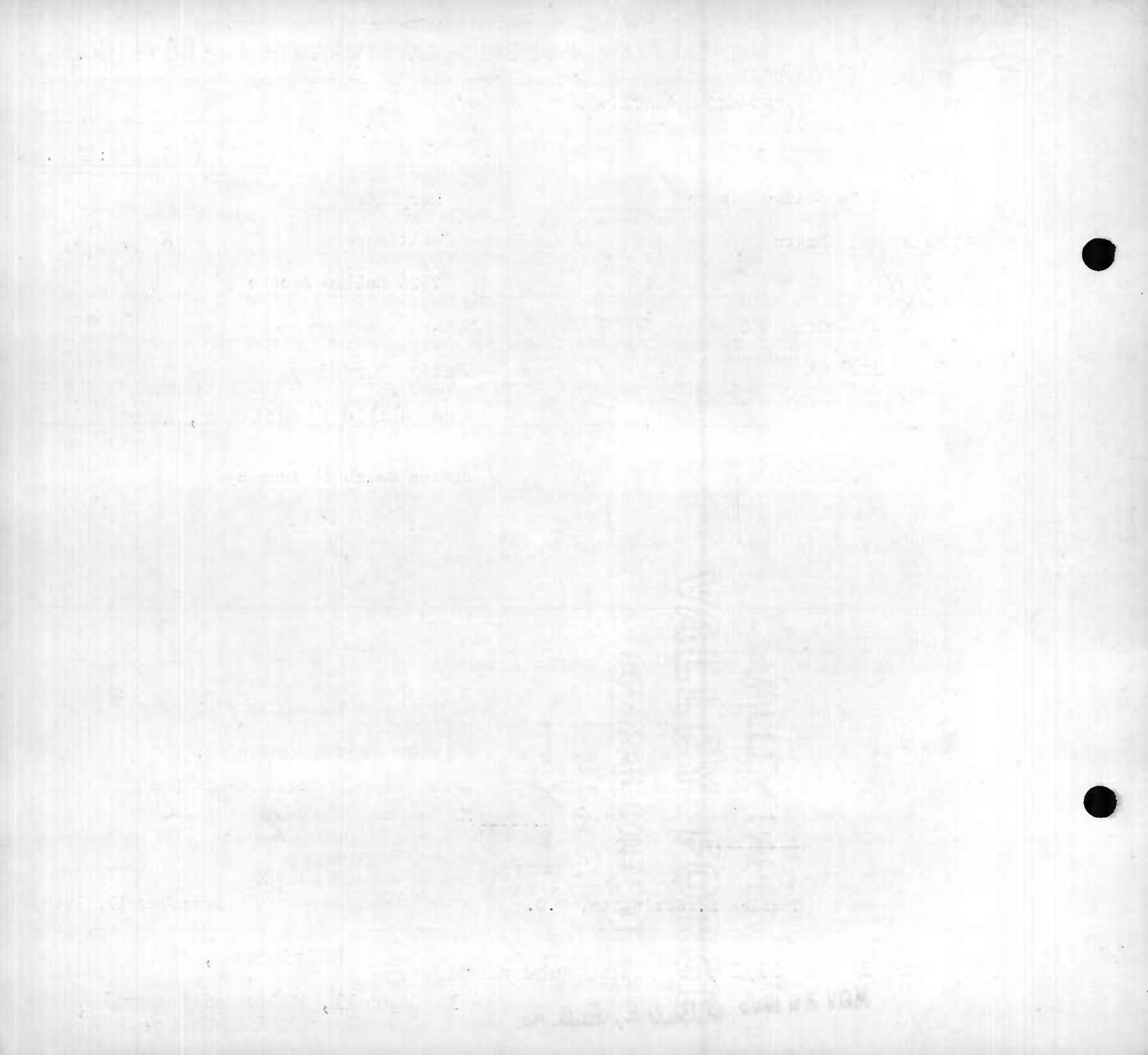
1. NAME OF DECEASED (Type or Print) MICHAEL LEDBETTER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) OR INSTITUTION 00 2426 Collow Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour November 17, 1968 8:15 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH 5/7/68		10. AGE (In years last birthday) 6 Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jesse Ledbetter		14. MOTHER'S MAIDEN NAME Julia Bradley	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. INFORMANT Mrs Julia Ledbetter, same		ADDRESS	

19. CAUSE OF DEATH 795X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Sudden death in infancy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 795.2 II			

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		November 17, 1968	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/23/68		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR I Carroll, Halstead Funeral Home		ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-11663	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 68-11663 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) ANNA TIROCCHI			2. DATE AND HOUR OF DEATH 11-17-68 2³⁰ P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSP.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 322 Albemarle St		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/10/97	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY RES.		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Anthony Annarelli			14. MOTHER'S MAIDEN NAME Scholastica Fusco		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS Medical Records.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 1 Nov. 4-68			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Satisfactory		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Anteriosclerotic Cardiovascular Disease		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Nov 12</u> 19 <u>68</u> to <u>Nov 17</u> 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Nov 17</u> 19 <u>68</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Song Suck Chung M.D.				23B. DATE SIGNED 11-17-68	
23C. PHYSICIAN'S NAME (Type) SONG Suck CHUNG M.D.				23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/20/68		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Maus Woodbury Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Frank Della Rocca 322 St.	

NOV 20 1968

2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11664

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ANTHONY Lee DOUGLAS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 11-16-68 Hour 12:15 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year 11-16-68 Hour 12:15 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3-2-1951		10. AGE (In years last birthday) 17 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Lucress Douglas	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mattie Faddell		ADDRESS Same	
19. E9661X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Stabwound of back		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID INJURY OCCUR? 600 block N. Aisquith St., 50' south of		22F. HOW DID INJURY OCCUR? Stabbed by unknown assailant	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 11-15-68 10:45 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		DATE SIGNED 11-16-68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-21-68	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Faddell	
25C. FUNERAL DIRECTOR Arlington Phillips		ADDRESS 1727 N. Main	

68-11665

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11665

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ERNEST HOLLEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2439 Woodbrook Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour November 16, 1968 7:05 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3-17-1885		10. AGE (In years last birthday) 83	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Norris Holley		14. MOTHER'S MAIDEN NAME Amanda Mitchell	
15. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Bernard M. Holley		ADDRESS 2436 Woodbrook Ave.	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
22A. DATE OF OPERATION 2		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22E. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) 2		22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22G. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DATE SIGNED November 17, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-20-68	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR William S. Phillips		ADDRESS 1727 N. Mount	

WALLLEY BONDING

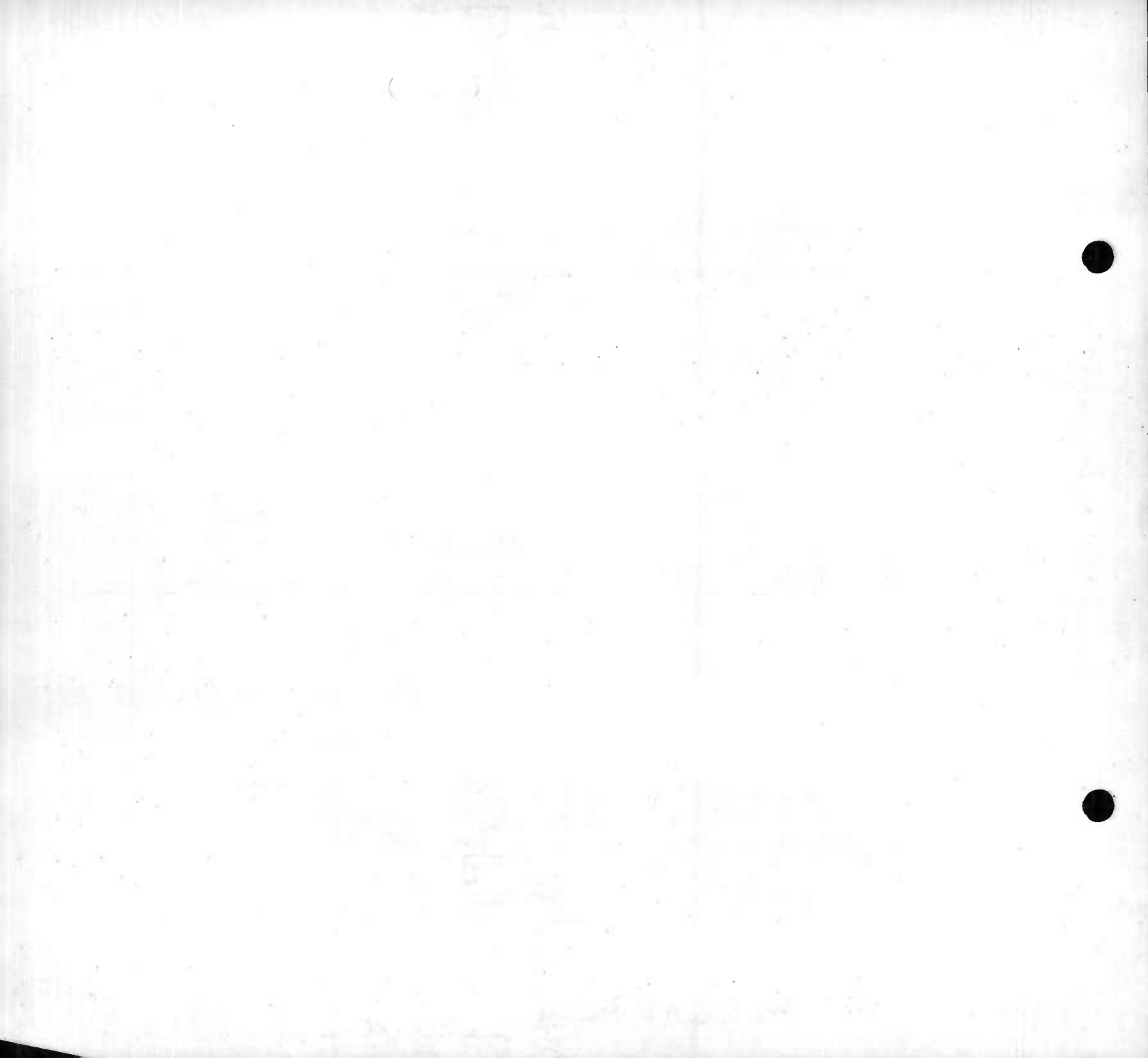
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11666 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11666

BIRTH NO.		1. NAME OF DECEASED (Type or Print) BEDDIE JACKSON		2. DATE AND HOUR OF DEATH 11-15-68 2:55AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 16-08			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 736 N. DENNISON ST.		5. SEX MALE 6. RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 6-1-1935		9. AGE (In years last birthday) 33		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Jackson		14. MOTHER'S MAIDEN NAME Nannie Rowlett	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-0954924		17. INFORMANT Mary Butts ADDRESS Same	
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE C.V.A.; Bilateral DUE TO, OR AS A CONSEQUENCE OF: (B) Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 11-4-1968 to 11-15-1968 , that we (we) last saw the deceased alive on 11-15-1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P. P. JOSHI		23B. DATE SIGNED 11-15-68		23C. PHYSICIAN'S NAME (Type) P. P. JOSHI	
23D. ADDRESS 730 ASHBURTON ST, BALTO-16		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11-20-68		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary A.B. Co.		24D. LOCATION (City, town, or county) (State) Md.	
25A. DATE NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR William J. Phillips	
25D. ADDRESS 1727 N. Mount					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11667 CERTIFICATE OF DEATH

REG. NO. ★

68-11667

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Linton, Walter</i> LINTON		2. DATE AND HOUR OF DEATH <i>11/17/1968</i> 11/17/1968 <i>4:20 P.M.</i> 4:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> Md. B. COUNTY <i>Carroll Co</i> Carroll Co		56-00	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> University Hospital <i>Baltimore Md. 21201</i> Baltimore Md. 21201		C. CITY OR TOWN <i>Sykesville</i> Sykesville		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <i>Sykesville Md. RF D 221784</i> Sykesville Md. RF D 221784		B. DATE OF BIRTH <i>7/8/1937</i> 7/8/1937		9. AGE (In years lost birthday) <i>71 years</i> 71 years	
5. SEX <i>male</i> male		6. RACE <i>white</i> white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i> retired		10B. KIND OF BUSINESS OR INDUSTRY <i>Store</i> Store		11. BIRTHPLACE (State or foreign country) <i>Maryland</i> Maryland	
13. FATHER'S NAME <i>JAMES E. Linton</i> JAMES E. LINTON		14. MOTHER'S MAIDEN NAME <i>Annie M. Frost</i> ANNIE M. FROST		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <i>No</i> No		16. SOCIAL SECURITY NO. <i>218-14-8147</i> 218-14-8147		17. INFORMANT <i>Mrs. Hollis Linton</i> Mrs. Hollis Linton	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>185X I</i> 185X I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary heart failure, carcinoma of prostate</i> Coronary heart failure, carcinoma of prostate (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction, renal failure</i> Myocardial infarction, renal failure (C) <i>Myocardial infarction, renal failure, carcinoma of prostate</i> Myocardial infarction, renal failure, carcinoma of prostate		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>177X II</i> 177X II					
19A. DATE OF OPERATION <i>11/13/68</i> 11/13/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of prostate</i> Carcinoma of prostate		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i> no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/17/68</i> 11/17/68 19 to <i>11/17/68</i> 11/17/68 19 that (I) (we) lost saw the deceased alive on <i>11/17/68 3 PM</i> 11/17/68 3 PM 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. N. J. M. D. resident</i> M. N. J. M. D. resident		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11-17-68</i> 11-17-68	
23C. PHYSICIAN'S NAME (Type) <i>Mohammed Nicksabht J. M. D.</i> Mohammed Nicksabht J. M. D.		23D. ADDRESS <i>University Hospital</i> University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> Burial		24B. DATE <i>11-21-68</i> 11-21-68		24C. NAME OF CEMETERY or CREMATORY <i>Freedom Cemetery</i> Freedom Cemetery	
24D. LOCATION (City, town, or county) (State) <i>Sykesville Md.</i> Sykesville Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i> Robert E. Jenkins		25C. FUNERAL DIRECTOR <i>Harry W. Haight</i> Harry W. Haight	
				ADDRESS <i>Sykesville</i> Sykesville	

NOV 21 1968

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11668</u>
BIRTH NO.		68-11668		
1. NAME OF DECEASED (Type or Print)		LAST MIDDLE FIRST		2. DATE AND HOUR OF DEATH
STEVENS, MINNETTE		MARY		11/19/68 4:20 AM
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
		C. CITY OR TOWN <u>16-02</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
42 SINAI HOSPITAL, INC.		E. STREET AND NUMBER <u>1109 North Calhoun ST</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/00</u>	9. AGE (In years lost birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>HOSEA SORRELL</u>		14. MOTHER'S MAIDEN NAME <u>ISHORRELL</u> MARIA JOHNSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>SARAH JOYNER SISTER 1109 NORTH CALHOUN ST. BALTIMORE, MD.</u>	
18. <u>412.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Vascular Accident</u>		
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>A SHD</u>		
		(C) <u>Hypertension</u>		
18. <u>331X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>11/18</u> 19 <u>68</u> to <u>11/19</u> 19 <u>68</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>11/19</u> 19 <u>68</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did not) view the body after death.				
23A. SIGNATURE <u>Eric Juditz M.D.</u>		23B. DATE SIGNED <u>11/19/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>ERIC JUDITZ M.D.</u>		23D. ADDRESS <u>SINAI HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>Nov. 23, 1968</u>	24C. NAME OF CEMETERY or CREMATORY <u>ST. JOHNS CEMETERY</u>	24D. LOCATION (City, town, or county) (State) <u>HOLLYWOOD, ST. MARY'S, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 21 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Farber</u>	25C. FUNERAL DIRECTOR ADDRESS <u>W. CLARKE MATTINGLEY LEONARDTOWN, MARY</u>		

11/10/72

11/10/72

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11/10/72

11/10/72

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11669

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY ELIA SWALES SWALES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <u>11</u> Day <u>18</u> Year <u>68</u> Estimated <input type="checkbox"/> <u>11</u> <u>18</u> <u>68</u>		Hour <u>10:45</u> a.m.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month <u>11</u> Day <u>18</u> Year <u>68</u> Hour <u>10:45</u> a.m.		
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>ST. MARY'S</u>		C. CITY OR TOWN <u>LEONARDTOWN</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
6. SEX <u>Female</u>	7. RACE <u>Colored</u>	E. STREET AND NUMBER <u>68-00</u>		
9. DATE OF BIRTH <u>Aug. 1, 1915</u>	10. AGE (In years last birthday) <u>53</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LUKE BARNES</u>		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <u>MARY DAVIS</u>		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT <u>VIRGIL SWALES</u> ADDRESS <u>LEONARDTOWN, MARYLAND</u>
19. <u>E 814.7</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Injuries</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>No</u>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>St. Rt. 5 & Church St.</u>
22D. TIME OF INJURY (APPROX.) <u>11 17 68 8:21 a.m.</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>XXX Pedestrian struck by auto</u>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Edward F. Wilson</u> M.D. EXAMINER'S NAME (Type) <u>Edward F. Wilson, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>November 18, 1968</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>Nov. 23, 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>ST. ALOYSIUS</u>
24D. LOCATION (City, town, or county) <u>LEONARDTOWN, ST. MARY'S, MARYLAND</u>		24E. LOCATION (State) <u>MARYLAND</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 21 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR ADDRESS <u>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</u>

W. A. Hubert

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X	68-11670
BIRTH NO. 68-11670		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CROWLEY, LILLIE J.			2. DATE AND HOUR OF DEATH NOVEMBER 17, 1968 2:00A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MARYLAND 21229			A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 08/14/81 9. AGE (In years last birthday) 87		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWING			11. BIRTHPLACE (State or foreign country) BALTO COUNTY Md.		
10B. KIND OF BUSINESS OR INDUSTRY RETIRED			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN CAVEY			14. MOTHER'S MAIDEN NAME ELIZABETH (LOWMAN) CAVEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 178039279A		
17. INFORMANT ST. AGNES RECORDS-BALTO., MD. 21229			ADDRESS		
18. 444.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Mesenteric Thrombosis, Gangrene of Stomach			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cirrhosis of Liver.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(B) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION 570.2 II			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			(If in Baltimore City, give exact location)		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOVEMBER 16, 1968 to NOVEMBER 17, 1968 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on NOVEMBER 17, 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE Wenifredo N. Iglesias M.D.			23B. DATE SIGNED 11/17/68		
23C. PHYSICIAN'S NAME (Type) WENIFREDO N. XME IGLESIA, M.D.			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/20/68		24C. NAME OF CEMETERY or CREMATORY ST. Johns	
24D. LOCATION Howard Co Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968			
25B. NAME OF REGISTRAR Robert E. Faulkner		25C. FUNERAL DIRECTOR 28 Mac Nabbs			
25D. ADDRESS 301 Frederick Rd		25E. ADDRESS BALTO.			

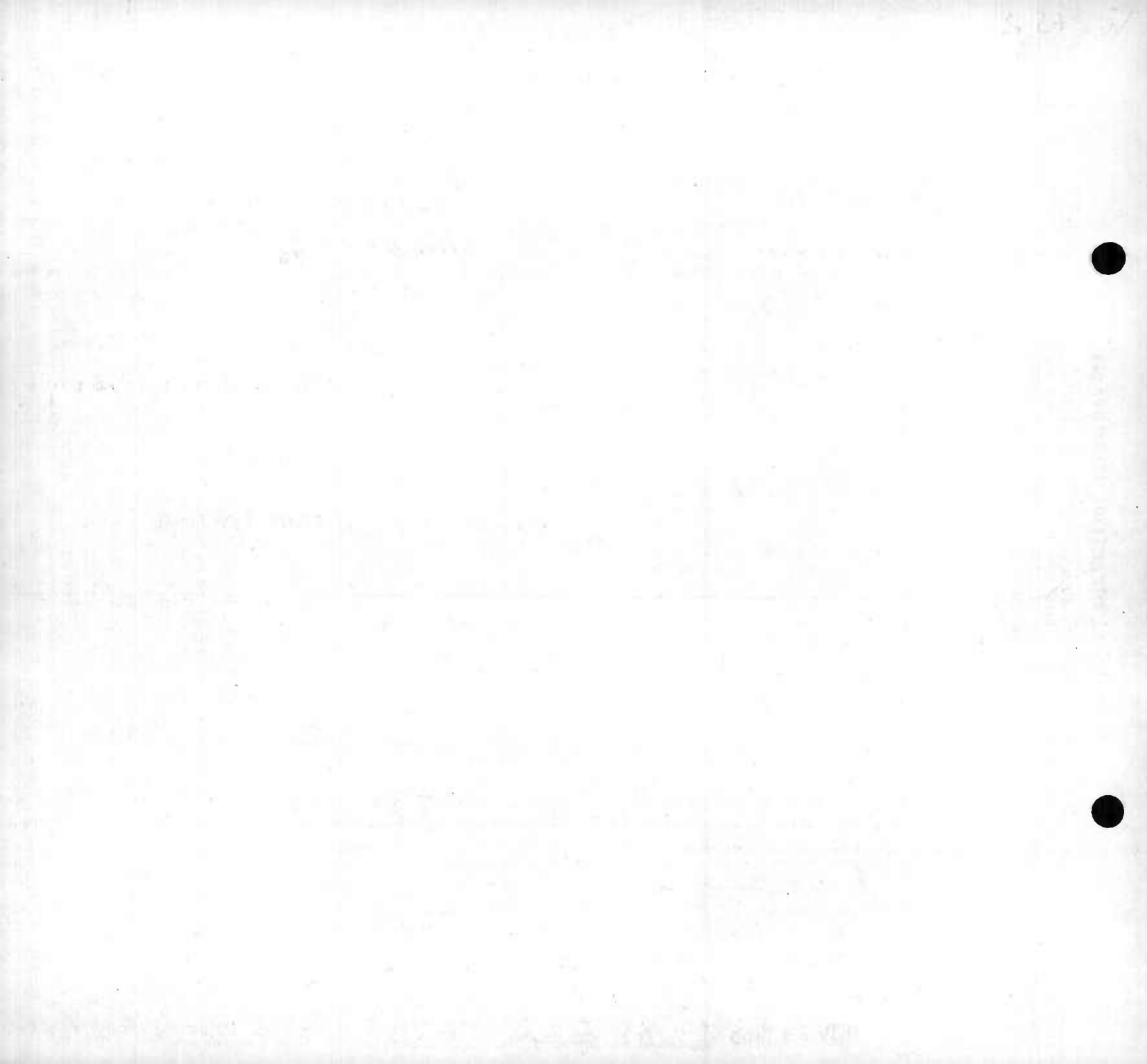
Self-Care

Self-Care
Self-Care
Self-Care

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11671</u>	
68-11671 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>WILLINGHAM THERESE</u>		2. DATE AND HOUR OF DEATH <u>NOV 18 '68</u> <u>6.00 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>U.S.A.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>36 FRANKLIN SQUARE</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>
			E. STREET AND NUMBER <u>KUPER Street 1304</u>		
5. SEX <u>Female</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/92</u>	9. AGE (In years lost birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINT OPERATOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
13. FATHER'S NAME <u>GEORGE ECKE</u>			14. MOTHER'S MAIDEN NAME <u>THERESE MOHMAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-10-4725</u>		17. INFORMANT <u>WILLIAM N WILLINGHAM</u> ADDRESS <u>518 LACIN AVE</u>	
18. <u>25091</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>HEART FAILURE</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>KIMMENSTEIL Wilson syndrome</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>BANGORENE Lt leg</u>		
			(C) _____		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>260X II</u>					
19A. DATE OF OPERATION <u>0 -</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>— NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>10-8</u> 19 <u>68</u> to <u>11-18</u> 19 <u>68</u> . that (I) (we) last saw the deceased alive on <u>11-18</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. Vanasini</u>				23B. DATE SIGNED <u>11/18/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>C. VANASINI M.D.</u>				23D. ADDRESS <u>FRANKLIN SQUARE HOSP</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-21-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>WESTERN CEMETERY</u>	
				24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 21 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>WALTERS FUN HOME PRATT & STRICKER STS</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11672	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Robert T. Carter			2. DATE AND HOUR OF DEATH Nov. 18, 1968		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 426 S. Wolfe St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2-02 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 426 S. Wolfe St.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-1908	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jesse Carter			14. MOTHER'S MAIDEN NAME Ella Carter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-4339	17. INFORMANT Marie Carter 426 S. Wolfe St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 0011.9 I CAUSE OF DEATH <i>steven's Pul. I.B.</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 hrs.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 002.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>off on since July 19 66</i> to <i>off on Nov 18, 1968</i> that (I) (we) last saw the deceased alive on <i>Nov 15, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. J. Feinglos</i> D. J. FEINGLOS				23B. DATE SIGNED NOV 21 1968	
23C. PHYSICIAN'S NAME (Type) D. J. FEINGLOS				23D. ADDRESS 2002 E. Pratt St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-20-68		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D. BY HEALTH DEPT. NOV 21 1968			
25B. NAME OF REGISTRAR Robert E. Feinglos		25C. FUNERAL DIRECTOR B. Dabrowski 2818 E. Baltimore St.			

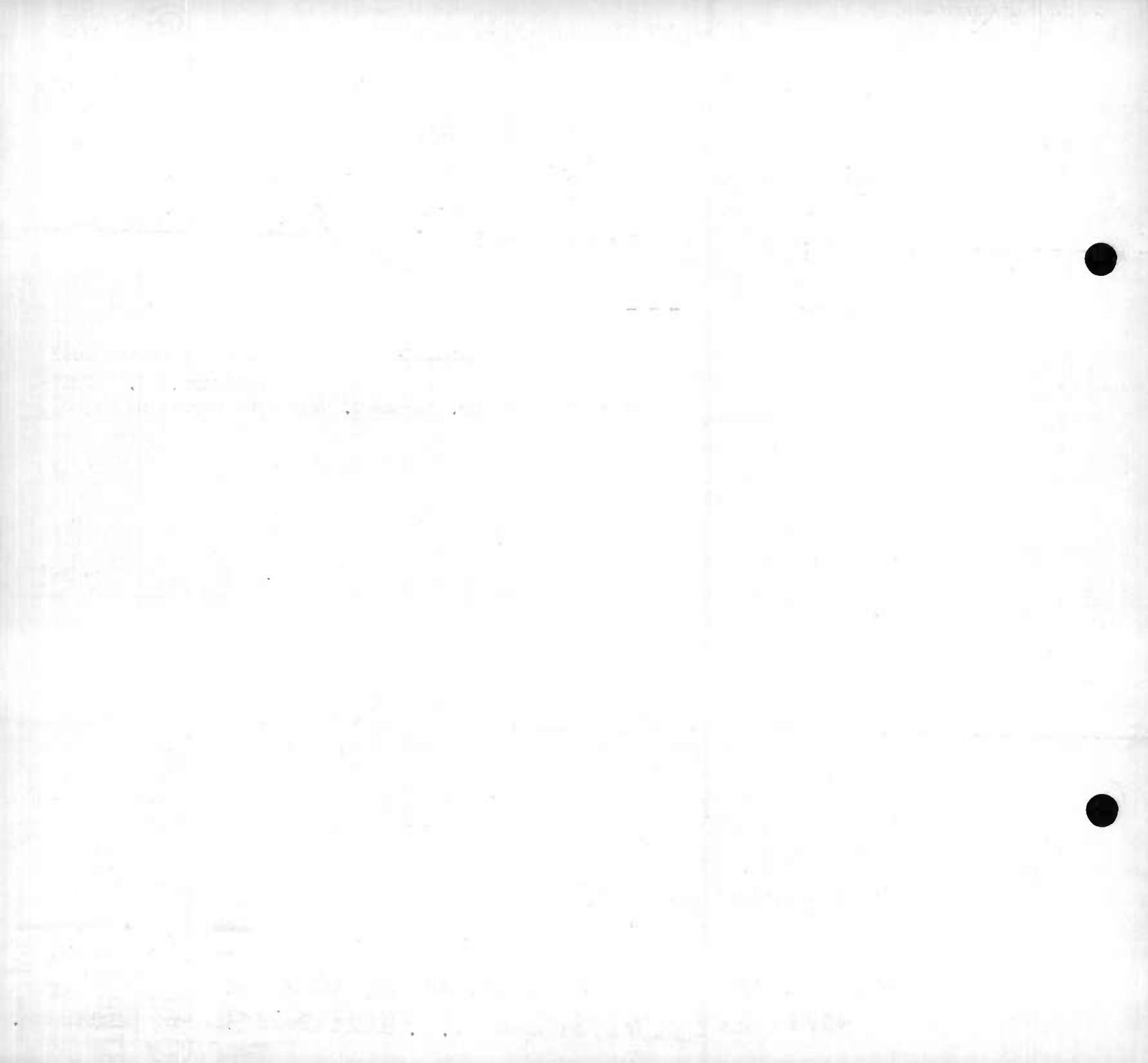
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11673 CERTIFICATE OF DEATH

REG. NO. 68-11673

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LENA B. WEST		2. DATE AND HOUR OF DEATH Nov. 17, 1968 12:45A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 27-19		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 00 5500 NARCISSUS AVE BALTO. MD. 21208		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH SEPT 6, 1895		9. AGE (In years last birthday) 73		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN ?		14. MOTHER'S MAIDEN NAME Evelyn May Norton Bell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-20-3771		17. INFORMANT Mr. Norman G. West 5500 Narcissus Avenue	
18. 571.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hepatic Failure Laennec's Cirrhosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Hepatic Failure DUE TO, OR AS A CONSEQUENCE OF: (C) Laennec's Cirrhosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 mo. 3 yrs.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8-21 1968 to 11-15 1968 , that (1) (we) last saw the deceased alive on 11-15 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lawrence Solomon M.D.		23B. DATE SIGNED 11-17-68		23C. PHYSICIAN'S NAME (Type) LAWRENCE SOLOMON M.D.	
23D. ADDRESS 3600 LOCHARN DR.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 20NOV68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Catonsville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR'S NAME J. E. Lowell Lemmon	
25D. ADDRESS 4611 Park Heights Ave.					



BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) NELSON, LENORA B.		NOVEMBER 16, 1968 3:15 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229		A. STATE MARYLAND B. COUNTY BALTO.	
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apt. house mgr.		E. STREET AND NUMBER 1402 SUMMIT AVE.	
10B. KIND OF BUSINESS OR INDUSTRY Retired		F. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN T. BARTON		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME FANNIE CREIGER	
16. SOCIAL SECURITY NO. 219-18-1710		17. INFORMANT AVES. - BALTO., MD. 21229 ST. AGNES RECORDS, WILKENS & CATON	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.9 S.S. #219-10-4798-A CARDIAC ARREST. (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ACUTE Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II Lum. fibrosis - severe.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 12 19 68 to NOVEMBER 16 19 68 , that (X) (we) last saw the deceased alive on NOVEMBER 16 19 68 and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.			
23A. SIGNATURE Alexandro Lopez		23B. DATE SIGNED 11/16/68	
23C. PHYSICIAN'S NAME (Type) ALEXANDRO MEJIA MD		23D. ADDRESS St Agnes Hospital Catons Wilkens Aves	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/20/68	
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem		24D. LOCATION (City, town, or county) (State) Pikesville BALTO. Co. MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR EB Mac Nab		25D. ADDRESS 301 Frederick Rd Balto 28 Md	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

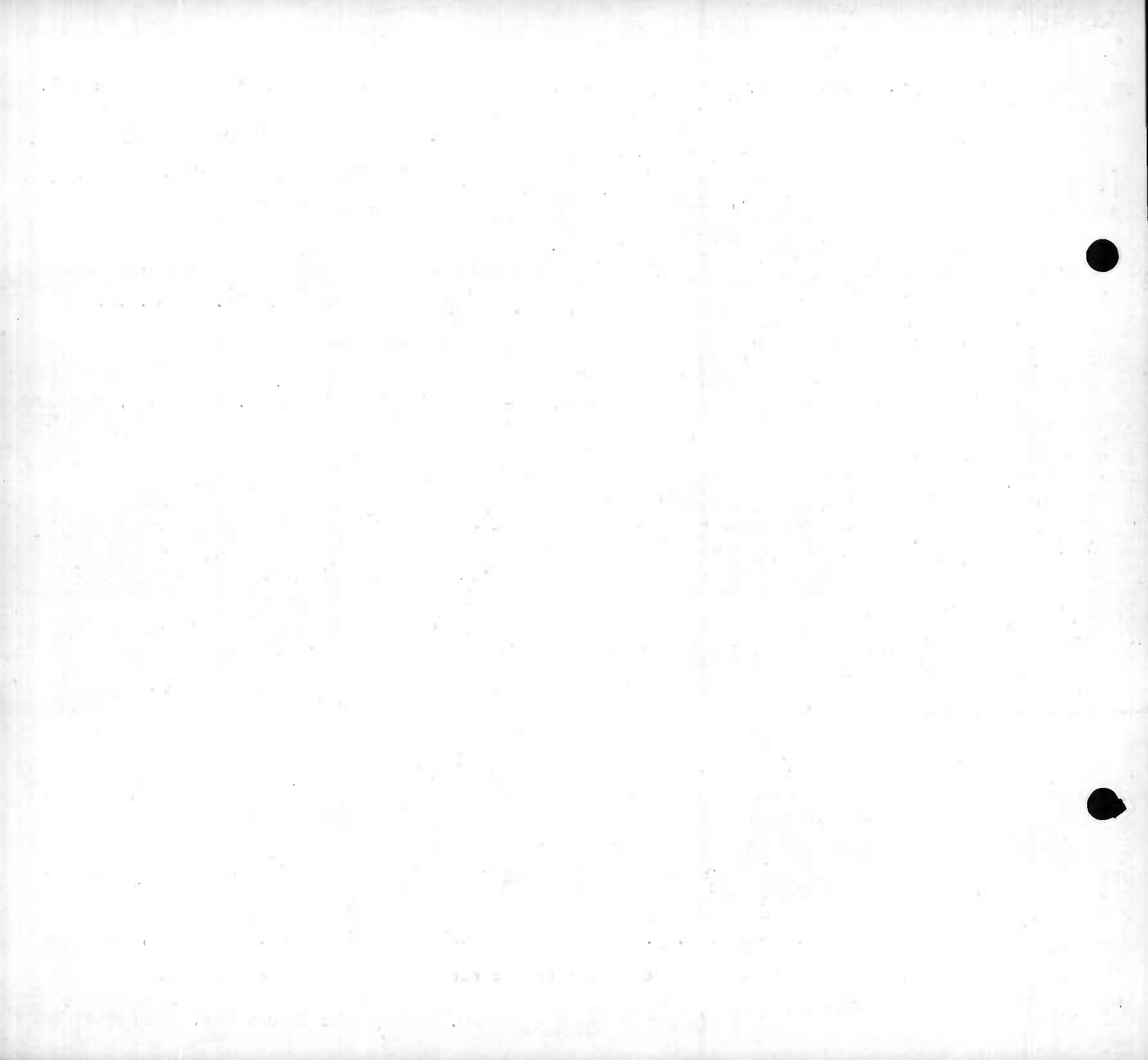
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11675 CERTIFICATE OF DEATH

REG. NO. 68-11675

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mrs. Elizabeth S. Ward		2. DATE AND HOUR OF DEATH November 19, 1968 2:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore City		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
FULL NAME OF HOSPITAL OR INSTITUTION 91 Jenkins Memorial Hospital 1000 Caton Avenue Baltimore, Maryland 21229		E. STREET AND NUMBER 4221 Fernhill Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/1873	9. AGE (In years last birthday) 94	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ocean, Allegheny Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Cunningham		14. MOTHER'S MAIDEN NAME Margaret Flanagan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-07-1420-D		17. INFORMANT Jenkins Memorial Hosp. Baltimore, Maryland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/10.9 I Myocardial Infarction 12 hours		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D. Years		(B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Arteriosclerosis - CVA - 4 years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct. 15 1968 to Nov. 19 1968 , that (I) (we) last saw the deceased alive on 19 Nov 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph E. Updike				23B. DATE SIGNED 19 Nov 68	
23C. PHYSICIAN'S NAME (Type) Ralph E. Updike, M. D.		23D. ADDRESS 1000 Caton Avenue Jenkins Memorial Hosp. Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/1968		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE RECEIVED NOV 21 1968			
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc. 1050 York Rd. Towson, Md. 21204			



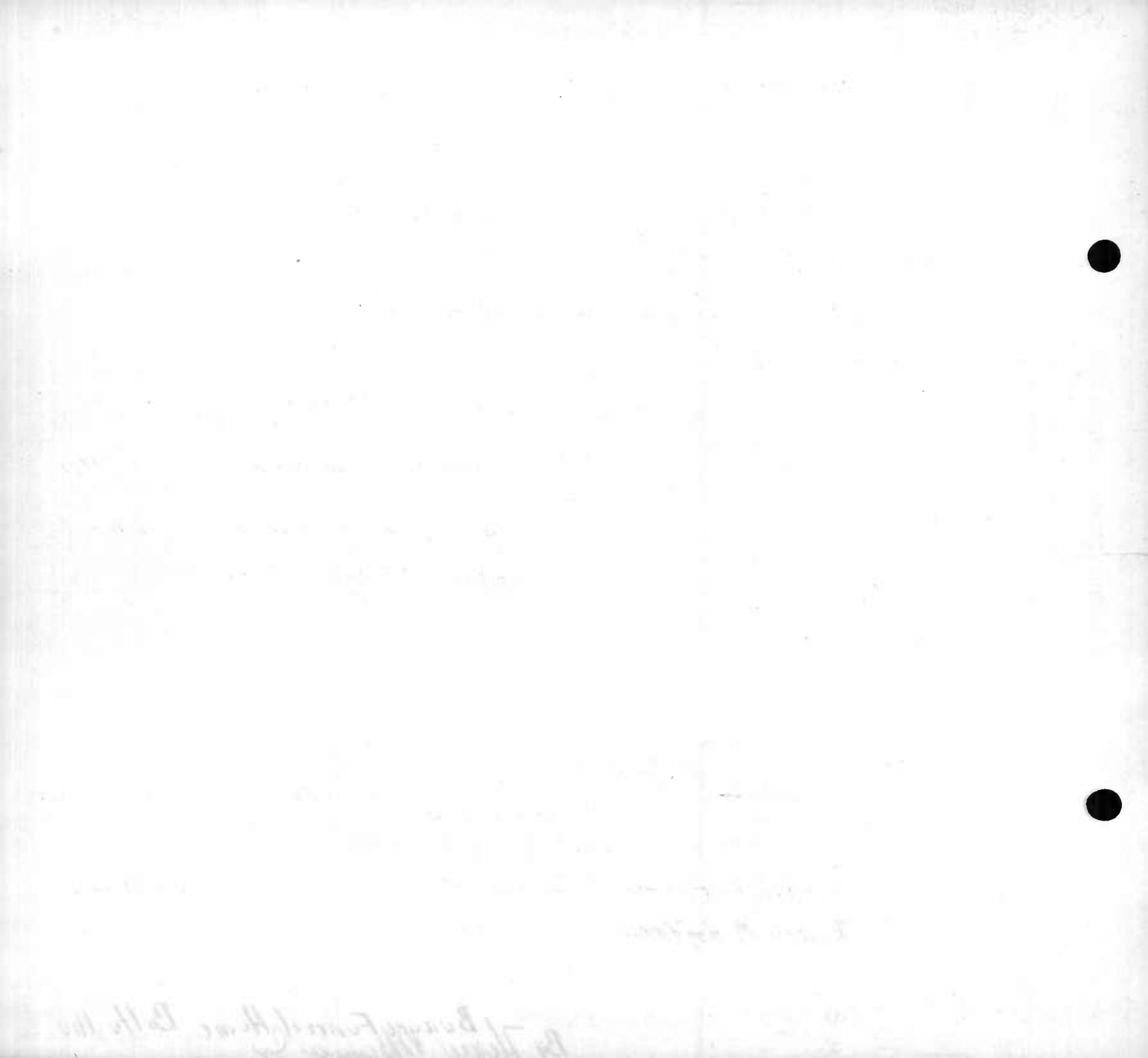
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11676 CERTIFICATE OF DEATH

REG. NO. 68-11676

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Charles C Wagner</i>		2. DATE AND HOUR OF DEATH <i>Nov 17, 1968 10⁵⁰ A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>13-05</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>3111 Keswick Road</i>				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>3111 Keswick Road</i>					
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-7-79</i>	9. AGE (In years lost birthday) <i>89</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Pool Engineering</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
13. FATHER'S NAME <i>Samuel S Wagner</i>				14. MOTHER'S/MAIDEN NAME <i>Emmeline Wolf</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212 01 4430-A</i>		17. INFORMANT <i>Eleanor Wagner 3111 Keswick Rd</i>	
18. <i>436.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Broncho-pneumonia</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cerebro-vascular accident</i>				(B) <i>1 month</i>	
(C) <i>Generalized arteriosclerosis</i>					
331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19 51</i> to <i>Nov. 17, 19 68</i> , that (I) (we) last saw the deceased alive on <i>Nov. 15, 19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE <i>Reuben M Hoffman, M.D.</i>				23B. DATE SIGNED <i>11-19-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Reuben M Hoffman</i>				23D. ADDRESS <i>846 W. 36th St., Baltimore, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>Nov 20</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greenmount Cem, York Pa</i>	
<i>Burial</i>				24D. LOCATION (City, town, or county) (State) <i>York Pennsylvania</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 21 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Scharf</i>		25C. FUNERAL DIRECTOR <i>Burgess Funeral Home Balto Md</i>	



By James M. Smith
Bureau of Forestry
Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print) MORRIS GEORGE MERLE				2. DATE AND HOUR OF DEATH 11-17-68 7 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION KESWICK 700 W. 40th ST.				A. STATE MARYLAND		B. COUNTY 12-01	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 116 W. UNIVERSITY PARKWAY							
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-18-89	9. AGE (In years last birthday) 79	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITOR-B&O R.R. RAILROAD				11. BIRTHPLACE (State or foreign country) Troy, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WESLEY MORRIS				14. MOTHER'S MAIDEN NAME FRANCIS SAUNDERS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I				16. SOCIAL SECURITY NO. UNDER RAIL ROAD RETIREMENT		17. INFORMANT P. M. Smith P.N.	
18. 437.9 I				CAUSE OF DEATH		ADDRESS 700 W 40th ST.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral vascular insufficiency		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Cerebral atherosclerosis DUE TO, OR AS A CONSEQUENCE OF:		5 yrs.	
				(C) Vascular insufficiency, legs		6 mos.	
334X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 28 Dec 1964 to 17 Nov 1968 , that (I) (we) last saw the deceased alive on 17 Nov 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE P. Hunter Wilson Jr MD				23B. DATE SIGNED 11-18-68			
23C. PHYSICIAN'S NAME (Type) F. Hunter Wilson MD				23D. ADDRESS			
24A. BURIAL CREMATION REMOVAL (Specify) Cremation		24B. DATE 11/19/68		24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Burger Funeral Home		ADDRESS Baltimore Md	

July 2 1900 (checked notes with my)

July 2 1900 (checked notes with my)

11-8-00

11-8-00

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G-622

68-11678 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11678

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

RONALD GROSS

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ November 16, 1968 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
OR INSTITUTION

Provident Hospital (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour
November 16, 1968 5:15 P.M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

6. SEX
Male7. RACE
Negro8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years last birthday)
28If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1611 Gwynns Falls Parkway

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Earl Carter

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Helen Gross

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

216-36-8510

18. INFORMANT

ADDRESS

Reuel Gross 2954 Second St Wash DC

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE Stabwound of chest
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

600 block of Collett Street

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

11-16-68 5:00 P. m.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Stabbed by unknown assailant

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 17, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Baltimore Md -
Earl Carter
Helen Hays

211-2200 Mrs. John Hays Hays

General Thos. J. M. M. M.
Baltimore Md.
211-2200 Mrs. John Hays Hays

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

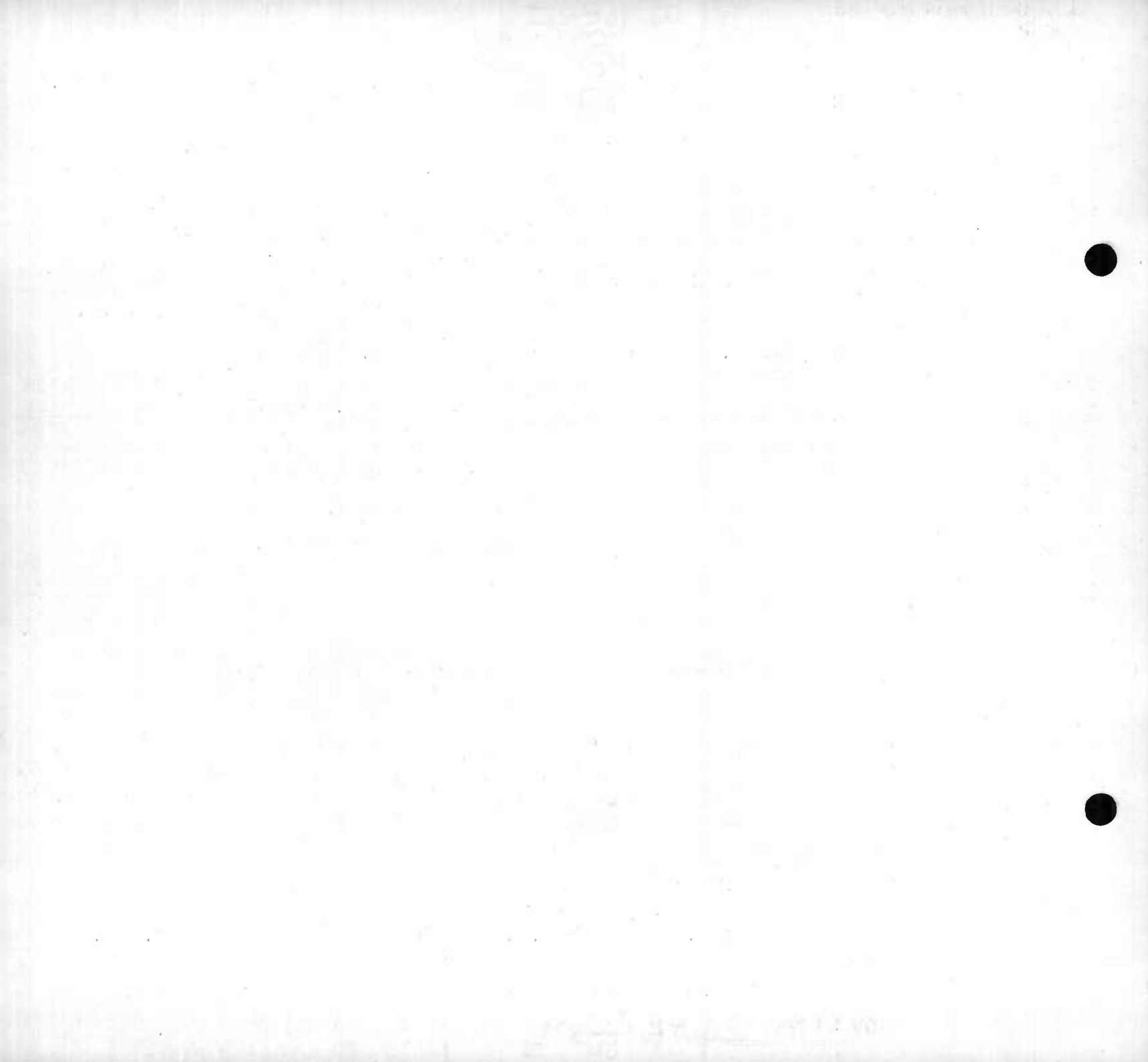
REG. NO. **68-11679**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Leticia A. Johnson		2. DATE AND HOUR OF DEATH 11/15/68 11:20 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 18 Maryland General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 18-38	
				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3541 Liberty Heights Ave	
5. SEX F	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/5/98	9. AGE (In years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Nelson Scott	
14. MOTHER'S MAIDEN NAME Mary Scott				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. ?				17. INFORMANT daughter - Dorothy Jones	
18. 400.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 445X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 445X II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours many years at least 4	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ?	
21D. TIME OF INJURY (APPROX.) 11/15/68		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 11/13 19 68 to 11/15 19 68 , that (I) (we) last saw the deceased alive on 11/15 19 68 and that in (my) () opinion death occurred on the date and hour and from the causes stated above. (I) () (did) () view the body after death.					
23A. SIGNATURE Ronice Kluge, MD				23B. DATE SIGNED 11/15/68	
23C. PHYSICIAN'S NAME (Type) Ronice Kluge MD				23D. ADDRESS Md General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-19-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Charles R. Law			
25D. ADDRESS 802 Madison Ave.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11680	
BIRTH NO. 68-11680		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) EMMA ABBOTT LAMBDIN			2. DATE AND HOUR OF DEATH NOVEMBER 18, 1968 5:15p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 115 Melrose Avenue Long Green Nursing Home			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 7-02 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 808 North Kenwood Avenue		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1880	9. AGE (In years last birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Christopher C. Hardester			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Anna M. Mitchell			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 218 52 1114		17. INFORMANT Mrs Henry A. Lowry		ADDRESS 21212 122 Melrose Avenue	
18. 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) INTERIO SCLEROSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION 450.0 II			20. AUTOPSY? (Yes or No) NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 8-11-65 to Nov 18 1968 , that (I) (we) last saw the deceased alive on Nov 18 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William G. Helfrich M.D.			23B. DATE SIGNED 11/20/68		
23C. PHYSICIAN'S NAME (Type) William G. Helfrich M.D.			23D. ADDRESS 5006 Roland Avenue Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/21/1968	24C. NAME OF CEMETERY or CREMATORY Mount Olivet Cemetery Baltimore Maryland		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE, MARYLAND 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11681

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11681

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Hawthorne, Catherine</i>		2. DATE AND HOUR OF DEATH 11-18-68 11:45 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>13-53</i>		C. CITY OR TOWN <i>Baltimore,</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>39 Provident Hospital, Inc.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>2254 Madison Avenue</i>					
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-1-20</i>	9. AGE (In years last birthday) <i>48</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Charles Davis</i>		14. MOTHER'S MAIDEN NAME <i>Lillian Jackson</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lillian Jackson-mother</i> ADDRESS <i>?Hoffman St, Apt 10</i>	
18. <i>486X I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia Bilateral</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>November 17, 1968</i> to <i>November 18, 1968</i> , that (I) (we) last saw the deceased alive on <i>November 18, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <i>11-18-68</i>			
23C. PHYSICIAN'S NAME (Type) <i>[Signature]</i>		23D. ADDRESS <i>1514 Division Street Balto., Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/22/68</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore, National</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 21 1968</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>Charles A. Rice</i>	
25D. ADDRESS <i>661 W. B...</i>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11682

CERTIFICATE OF DEATH

REG. NO.

68-11682

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Fannie Dawson		2. DATE AND HOUR OF DEATH 11/20/68 4:45 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hosp.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 814 George St	
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/98	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John H Booze			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war and dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Charles Samorodin M.D. ADDRESS	
18. 450X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 465X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 11/15/68 19 68 to 11/20/68 19 68 , that (I) (we) last saw the deceased alive on 11/20 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Charles Samorodin M.D. DEGREE				23B. DATE SIGNED 11/20/68	
23C. PHYSICIAN'S NAME (Type) Charles S. Samorodin M.D. DEGREE				23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-23-68		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. LOCATION (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Bore St. ADDRESS	

11/18/88
814 658
D. A. Jones

11/18/88
814 658
D. A. Jones

Charles Jones A.D.

Previous to 11/18/88
D. A. Jones

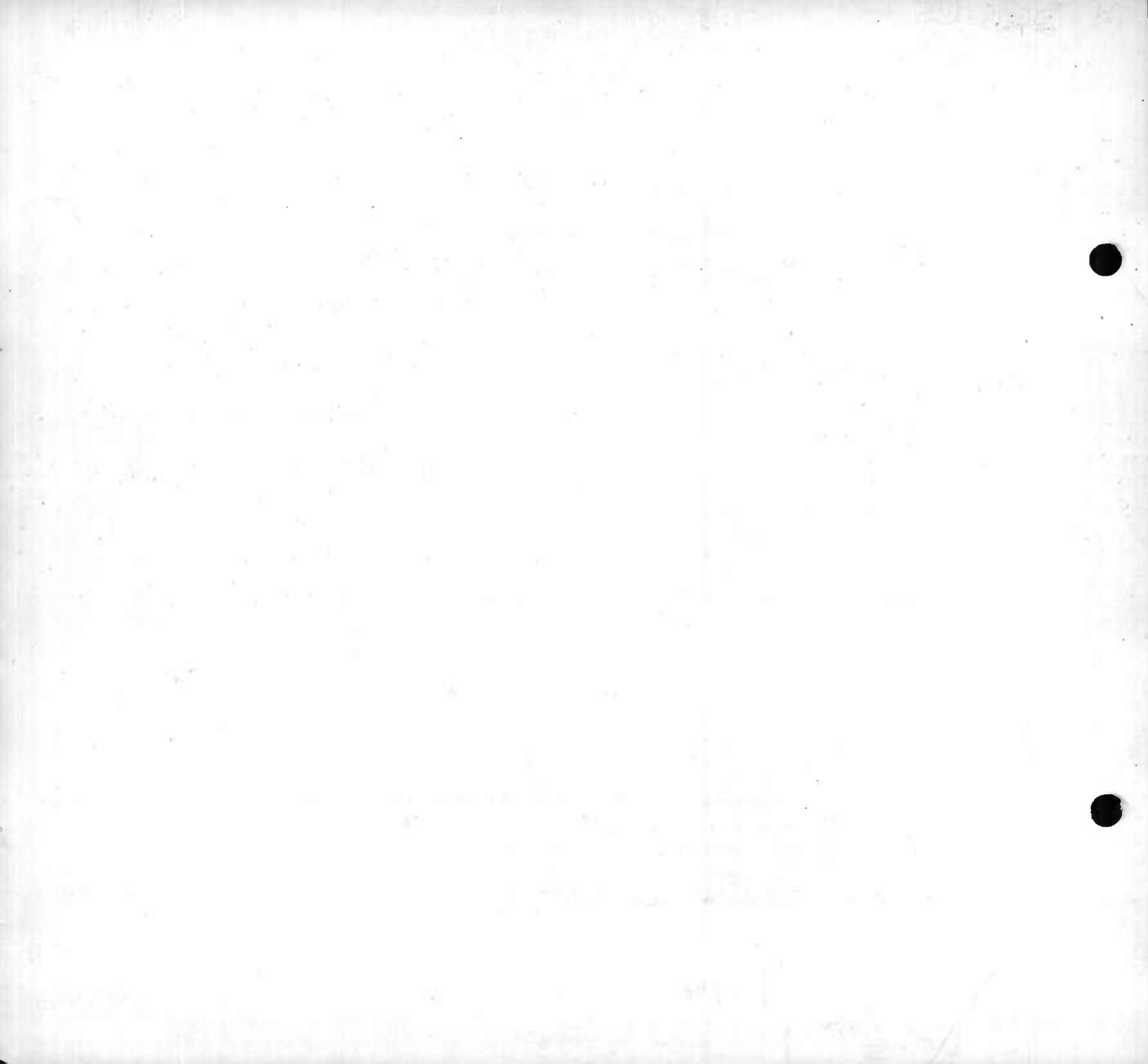
Charles Jones A.D.
11/18/88

11/18/88
D. A. Jones

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-21447		68-11683		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11683	
1. NAME OF DECEASED (Type or Print) BABY BOY DYSON				2. DATE AND HOUR OF DEATH 11/4/68 1:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MD. HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 15-02			
5. SEX M		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/4/68	
9. AGE (In years last birthday)		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES Dyson				14. MOTHER'S MAIDEN NAME Shirley Brooks			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 777 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: IMMATURITY (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MIN.	
19. 776 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/4/68 to 11/4/68 , that (I) (we) last saw the deceased alive on 11/4/68 and that (my) (our) apthian death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John Ignatowski M.D.				23B. DATE SIGNED 11/7/68		23C. PHYSICIAN'S NAME (Type) John Ignatowski	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/15/68		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11684		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11684	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Murray R. FITZHUGH		27 October 1968 10:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND BALTIMORE CITY BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
38 UNIVERSITY OF MARYLAND HOSPITAL		E. STREET AND NUMBER 406 N. PINE ST.			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/19/94	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) UNKNOWN	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASPIRATION INTESTINAL OBSTRUCTION DUE TO CARCINOMA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MIN SEVERAL WEEKS	
MEDICAL CERTIFICATION 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 153.8 II					
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from 20 October 19 68 to 27 October 19 68, that (he) (we) last saw the deceased alive on 27 October 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Susan Howard Matlier M.D. DEGREE				23B. DATE SIGNED 27 Oct 68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11-15-68		24C. NAME of CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL HOSPITAL DISPOSAL	

11-12-08

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11685 CERTIFICATE OF DEATH

REG. NO. 68-11685 4

BIRTH NO. 68-21506

1. NAME OF DECEASED
(Type or Print)

Baby Boy Nessel Road

2. DATE AND HOUR OF DEATH

November 9, 1968 9:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

Maryland Anne Arundel Co

C. CITY OR TOWN

Crownsville

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

267 Shore Drive

52-00

5. SEX

Male

6. RACE

White

7. MARRIED

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

Nov. 9, 1968

9. AGE (In years last birthday)

Newborn

If Under 1 Yr. Months: Days

41

If Under 24 Hrs. Hours: Min.

41

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

LARRY Dale Nessel Road

14. MOTHER'S MAIDEN NAME

Betty Joyce Dunn

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 776.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Atelectasis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

45 min

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

762.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from Nov. 9, 1968 8:15 PM to Nov. 9, 1968 9:05 AM that (we) last saw the deceased alive on Nov. 9, 1968 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Raymond A. Nessel Road MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11-9-68

23C. PHYSICIAN'S NAME (Type)

Raymond A. Nessel Road MD

23D. ADDRESS

South Baltimore Board of Health, Maryland

24A. BURIAL CREMATION REMOVAL (Specify)

24B. DATE

11/18/68

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

State

UNIVERSITY MEDICAL SCHOOL

25A. DATE RECEIVED BY HEALTH DEPT.

NOV 21 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHD

At present the only thing
that is going on is a
few small things.

There is a great deal of
work to be done.

There is a great deal of
work to be done.

11/10/10

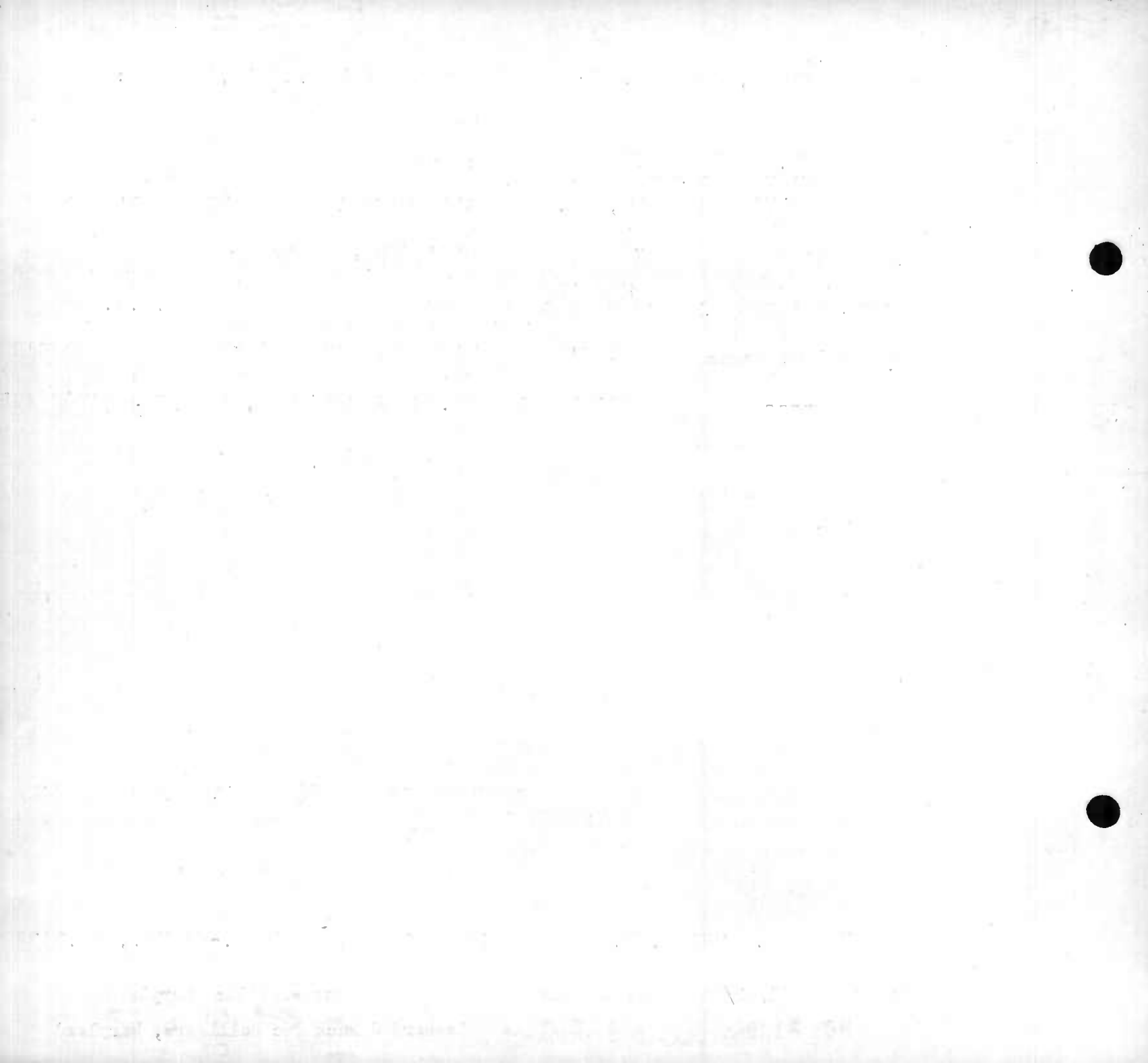
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11686 CERTIFICATE OF DEATH

REG. NO. 68-11686

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		OZMAN, JOHN LUTHER		NOVEMBER 19, 1968 7:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 21229, MD.				A. STATE MARYLAND	
				B. COUNTY Baltimore	
5. SEX MALE				6. RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 01/16/1909 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PAINTER				10B. KIND OF BUSINESS OR INDUSTRY HOSPITAL CHURCH HOME &	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William Ozman				14. MOTHER'S MAIDEN NAME VIRGINIA (THOMAS) OZMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 213018263	
17. INFORMANT ST. AGNES HOSPITAL, WILKENS & CATON AVE				ADDRESS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 154.1 I Intestinal Obstruction 20 To Carcinoma of rectum					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 154X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 12 1968 to NOVEMBER 19 1968, that (I) (we) last saw the deceased alive on NOVEMBER 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ruben V. Luna				23B. DATE SIGNED 11-19-68	
23C. PHYSICIAN'S NAME (Type) RUBEN V. LUNA M. D.				23D. ADDRESS CATON & WILKENS AVES.-BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/68		24C. NAME OF CEMETERY or CREMATORY Stevensville	
24D. LOCATION Stevensville Maryland		24E. DATE REC'D BY HEALTH DEPT. NOV 21 1968			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) MRS. DOROTHY DOTSON FELDER				2. DATE AND HOUR OF DEATH 11/9/68 9:30 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME AND HOSPITAL 100 N. BROADWAY BALTIMORE, MARYLAND 21231				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 21231				F. CITY OR TOWN BALTIMORE			
5. SEX F		6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 50	
9. AGE (In years last birthday) 50		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINE	
13. FATHER'S NAME JAMES BROWN				14. MOTHER'S MAIDEN NAME MARY ANN RICHARDSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. E980.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Right Lower Lobe Pneumonia 8 weeks				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Confinement to bed, decubitus Over 8 weeks			
				(B) DUE TO, OR AS A CONSEQUENCE OF: ulcer buttocks, Epilepsy for 30 yrs			
				(C) barbiturate poisoning, Epilepsy			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I							
19A. DATE OF OPERATION 10/3/68 10/22/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Buttocks Decubitus Ulcer		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Does not apply			
21D. TIME OF INJURY (APPROX.) Does not apply		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Does not apply			
22. I certify that 1 (this hospital) attended the deceased from 9/16/1968 to 11/9/1968 , that we last saw the deceased alive on 11/9/1968 and that in our opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.							
23A. SIGNATURE A. F. AZAM				23B. DATE SIGNED 11/9/1968			
23C. PHYSICIAN'S NAME (Type) A. F. AZAM				23D. ADDRESS Church Home & Hospital Baltimore, Md. 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) 11-15-68		24B. DATE		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Garbman		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	

NOTED

Right lower late Pleistocene

Conformable to bed, characteristic
of the late Pleistocene
glacial period

Butterfly Description when
none

See next page
11/11/11

11/11/11
X
Chung Hwa & Hsueh
11/11/11

A. F. ASAN

11/12/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11688 CERTIFICATE OF DEATH

REG. NO. 68-11688

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>DAVID S. PHILLIPS</u>		2. DATE AND HOUR OF DEATH <u>11-20-68</u> <u>7:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>25-31</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>34</u> <u>BON SECOURS HOSPITAL</u>		E. STREET AND NUMBER <u>5146 STAFFORD RD.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-94</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Cross & Blackwell</u>		11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>DAVID PHILLIPS</u>		14. MOTHER'S MAIDEN NAME <u>Maria Powell</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-10-7476</u>		17. INFORMANT <u>Mrs. Elizabeth R. Phillips, 5146 Stafford Rd.</u>	
18. <u>427.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory failure</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic heart failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7:30 A.M. 11-20-68</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>434.1</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic pancreatitis</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>		(C) <u>years</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-30</u> 19 <u>68</u> to <u>11-20</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-20</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>11-20-68</u>		23C. PHYSICIAN'S NAME (Type) <u>JOHNNY T. YAP M.D.</u>	
23D. ADDRESS <u>BON SECOURS HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-23-68</u>	
24C. NAME of CEMETERY or CREMATORY <u>Moreland Mem. Pk. Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>2901 Taylor Ave. Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 21 1968</u>	
25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25D. ADDRESS	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11689
BIRTH NO. <u>Carroll Co. Md.</u> 68-11689		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) TERESA LYNN HEATH		2. DATE AND HOUR OF DEATH NOV. 19 1968 1:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL 38 BALTO. Md #1201		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY Baltimore Co. 53-00		
5. SEX F 6. RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) md		9. AGE (In years last birthday) NOV. 7 1968
13. FATHER'S NAME RONALD HEATH		14. MOTHER'S MAIDEN NAME LINDA SINNOTT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		12. CITIZEN OF WHAT COUNTRY? USA
17. INFORMANT Kenneth R Koskinen MD		ADDRESS		
18. 746.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Congenital heart disease (A) IMMEDIATE CAUSE DUE TO OR AS A CONSEQUENCE OF: IASD IVSD PDA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 754.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22. I certify that (I) (this hospital) attended the deceased from 11/17 19 68 to 11/19 19 68 , that (I) (we) last saw the deceased alive on 11/19 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Kenneth R Koskinen MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/19/68
23C. PHYSICIAN'S NAME (Type) KENNETH R KOSKINEN MD		23D. ADDRESS University Hosp Balto md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov. 20, 1968	24C. NAME of CEMETERY or CREMATORY Evergreen Mem. Gardens		24D. LOCATION (City, town, or county) (State) Finksburg, Maryland.
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Sweeney		25C. FUNERAL DIRECTOR H. J. Schhardt Owings Mills, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11690				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11690	
BIRTH NO. <u>Augustyniak</u>							
1. NAME OF DECEASED (Type or Print) <u>Mrs Mary Augustyniak</u>				2. DATE AND HOUR OF DEATH <u>11-18-68</u> <u>11:37A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Ches Ch House & Hospital</u> <u>35</u>				A. STATE <u>✓</u>		B. COUNTY <u>1-03</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>6-15-93</u>		9. AGE (In years last birthday) <u>75</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Anthony Kalaczinski</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or forces of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>212-07-9054</u>		17. INFORMANT <u>MR. FRANK AUGUSTYNIAK</u> <u>Hubert</u>	
18. <u>41213</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>420.0 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>—</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJECTION (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJECTION OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJECTION (Month) (Day) (Year) (Hour) (Approx.) 21E. INJECTION OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJECTION OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>10:30</u> to <u>11-18-68</u> that (I) (we) last saw the deceased alive on <u>11-18-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>[Signature]</u> DEGREE <u>—</u> 23B. DATE SIGNED <u>11-18-68</u> 23C. PHYSICIAN'S NAME (Type) <u>DR. A. E. SUBONGNE</u> DEGREE <u>—</u> 23D. ADDRESS <u>Church House & Hospital</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 24B. DATE <u>11/22/68</u> 24C. NAME of CEMETERY or CREMATORY <u>ST. STANISLAUS CEMETERY</u> 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u> 25A. DATE RECEIVED BY HEALTH DEPT. <u>NOV 21 1968</u> 25B. NAME OF REGISTRAR <u>Robert E. Jarboe</u> 25C. FUNERAL DIRECTOR <u>RAYMOND L. KACZOROWSKI</u> ADDRESS <u>2525 FLEET ST.</u>							

11-14-1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11691	
BIRTH NO. SKRUCH		68-11691 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Margaret Skruch		2. DATE AND HOUR OF DEATH 11-16-68 10:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 1-03			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4 South Baltimore General Hospital 3001 S. KENNEDY ST., Baltimore		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 516 S. ROSE ST.					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-87	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Europe	
12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME Z		14. MOTHER'S MAIDEN NAME Z			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MISS ANNA SKRUCH 516 S. ROSE ST. admission sheet	
18. 412.412509 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE CVA DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetic Mellitus, Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11:30 AM 11-5-68 to 10:20 PM 11-16-68, that (I) (we) last saw the deceased alive on 11-16-68 10:20 PM 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. G. Baumann		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/16/68	
23C. PHYSICIAN'S NAME (Type) C. G. BAUMANN MD		23D. ADDRESS South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/20/68		24C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Jankowski		25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI 2525 FLEET ST.	

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68-11692 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11692

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIE MELVIN MARTIN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> Unknown UNK M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) (Harbor) Key Highway & Woodall		3. DATE PRONOUNCED DEAD Month Day Year Hour November 2, 1968 10:10 AM	
6. SEX male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8/15/31		10. AGE (In years lost birthday) 37	
11. BIRTHPLACE (State or foreign country) Ba No. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		14B. KIND OF BUSINESS OR INDUSTRY none	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. Reverin Martin same	
18. INFORMANT Reverin Martin same		ADDRESS same	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease	
20. 422.1 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) Yes	
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 20, 1968	
24C. NAME OF CEMETERY or CREMATORY MT. Auburn		24D. LOCATION (City, town, or county) (State) Balt. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Elmer O. Watson		ADDRESS 1100 E. Pratt St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11693	
1. NAME OF DECEASED (Type or Print) Lillian Harris		2. DATE AND HOUR OF DEATH 11/20/68 1 ¹⁵ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		A. STATE Maryland C. COUNTY Baltimore City C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 728 W. Dolphin St.			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/07	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balto. Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Edwards		14. MOTHER'S MAIDEN NAME Katie Taylor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no & unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Marthy Vaughn 3000 Hillen 50		
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolus			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Paraplegia DUE TO, OR AS A CONSEQUENCE OF:			2 wks.
		(C) Metastatic Ca of Breast to spine			3 yrs.
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 11/6/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED acute Pancreatic		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 11/6 19 68 to 11/20 19 68 , that (1) (we) last saw the deceased alive on 11/20 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joe U. Levi M.D.		23B. DATE SIGNED 11/20/68		23C. PHYSICIAN'S NAME (Type) Joe U. Levi M.D.	
23D. ADDRESS JHH		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11-25-68		24C. NAME OF CEMETERY or CREMATORY Balto. Nat. Cent.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Eloy Wilson 1000 B. Southy Rd.	

John Schuster

Kate Schuster

Form No. 2

John Schuster

John Schuster

John Schuster

John Schuster

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11/1/68

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68-11694 BALTIMORE CITY HEALTH DEPARTMENT

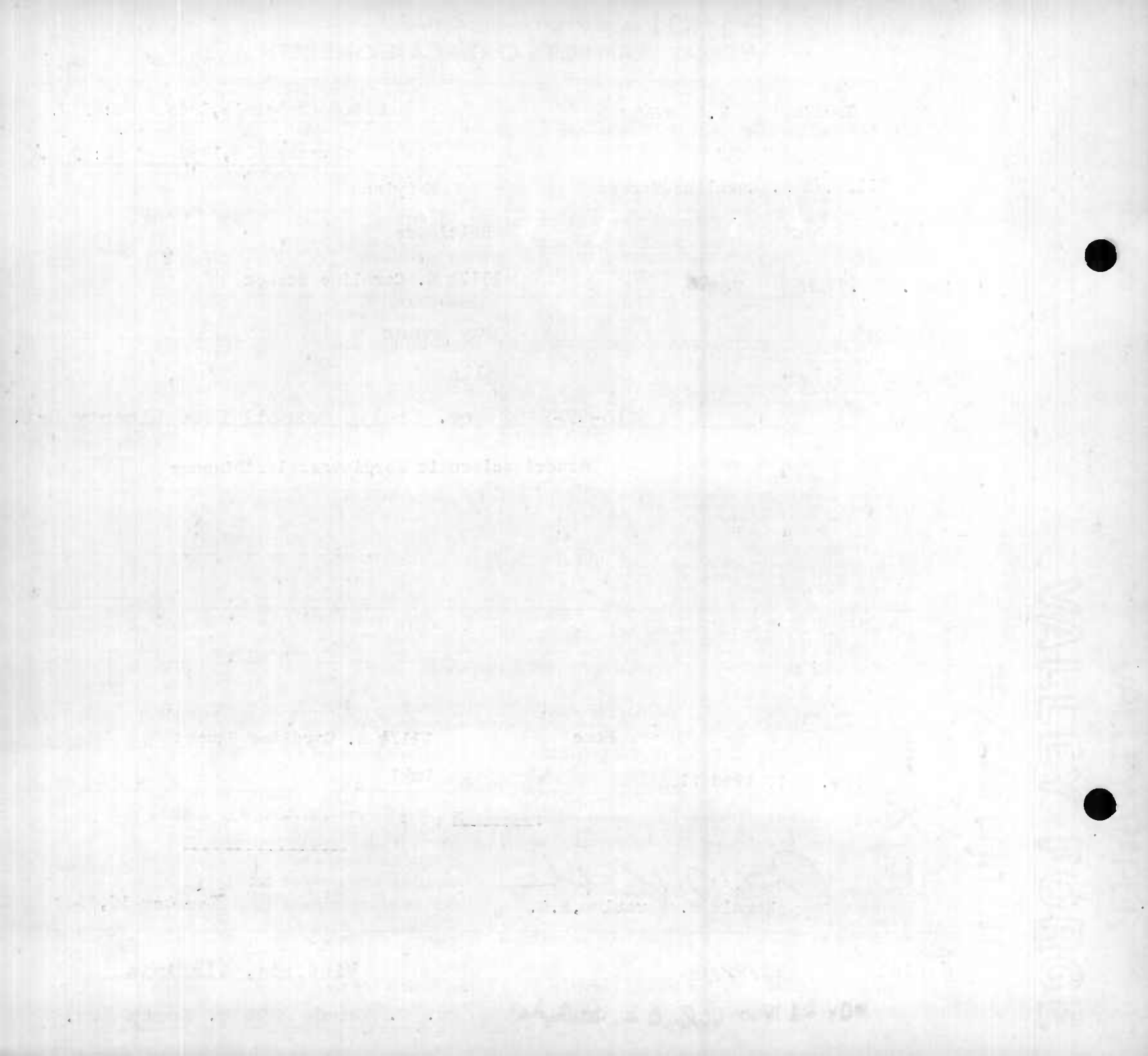
68-11694

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE R. EVANS				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 18, 1968 8:45 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1117 1/2 N. Caroline Street				3. DATE PRONOUNCED DEAD Month Day Year November 18, 1968 8:45 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-07					
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Feb. 28, 1893				10. AGE (In years last birthday) 75	
11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker				14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes				17. SOCIAL SECURITY NO. 213-07-9493	
18. INFORMANT Mrs. Ethlyn Gosnell				ADDRESS 2406 Liberty Hgts	
19. CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME OF INJURY (APPROX.) Month (Month) (Day) (Year) (Hour) Nov. ?? 1968 ?? m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1117 1/2 N. Caroline Street				22F. HOW DID INJURY OCCUR? Unk?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 19, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/68		24C. NAME OF CEMETERY or CREMATORY Victoria, Virginia	
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1968		25B. NAME OF REGISTRAR <i>Robert E. Tinsley</i>		25C. FUNERAL DIRECTOR Wm. C. March 928 E. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11695</u>
BIRTH NO. <u>52-97-27</u>		68-11695 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Makoris, James</u>		2. DATE AND HOUR OF DEATH <u>11/11/68</u> <u>2:15</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND 21224</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <u>920 NORTH CALVERT STREET</u> <u>21202</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-97</u>	9. AGE (In years last birthday) <u>71</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>BCH: RECORDS 4940 EASTERN AVENUE</u>
18. <u>01147</u> I <u>I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Tuberculosis, pulm</u> <u>several mo.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Malnutrition</u> <u>several mo</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>002.1 II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from <u>11/4</u> 19 <u>68</u> to <u>11/11</u> 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>11/11</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Mary Ann Sullivan M.D.</u>		23B. DATE SIGNED <u>11/11/68</u>		23C. PHYSICIAN'S NAME (Type) <u>DR. MARY ANN SULLIVAN M.D.</u>
23D. ADDRESS <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND 21224</u>		23E. PHYSICIAN'S DEGREE <u>DEGREE</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>11-19-68</u>	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 22 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>



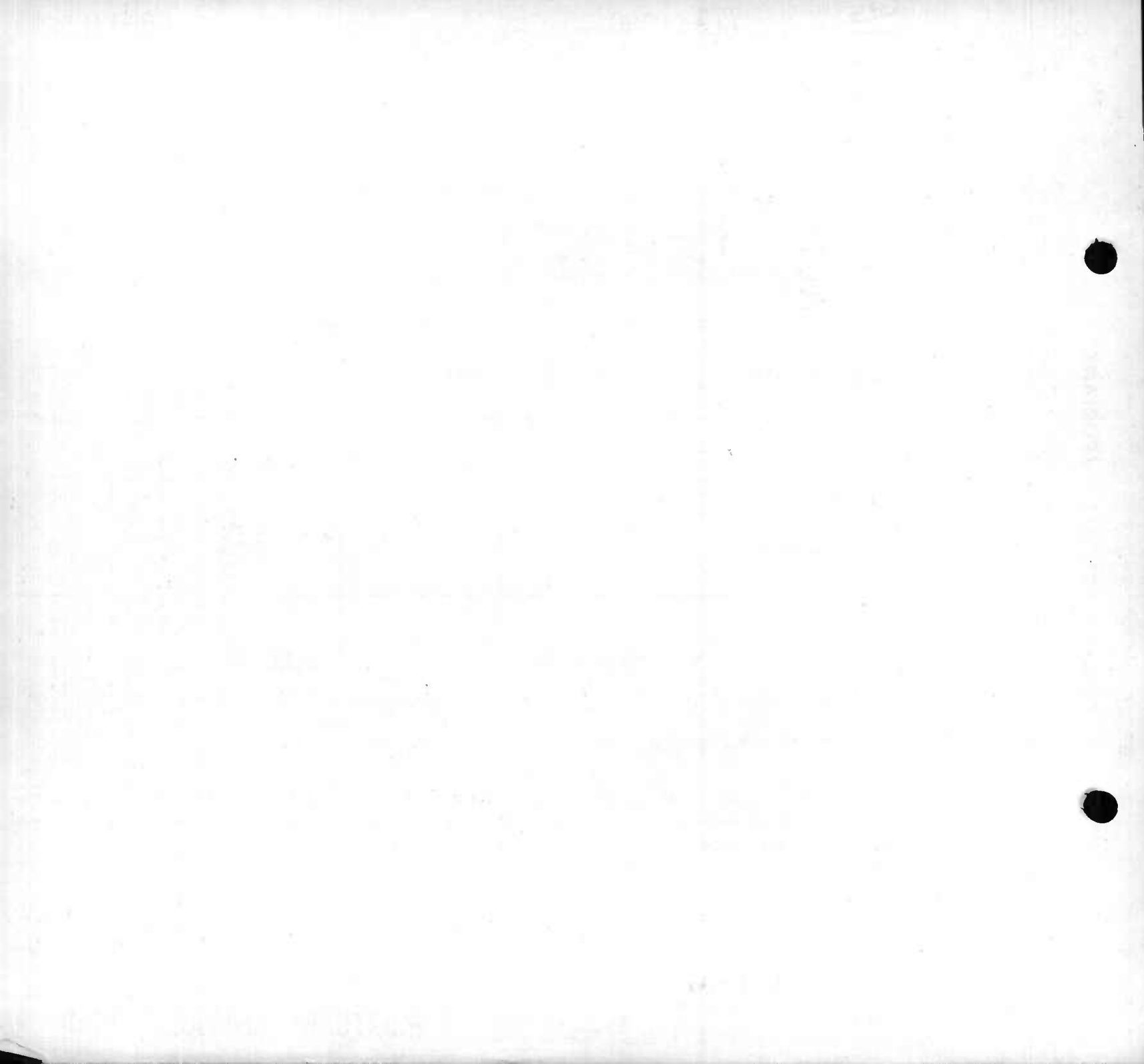
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11696 CERTIFICATE OF DEATH

REG. NO. 68-11696

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Nathan Walker</u>		2. DATE AND HOUR OF DEATH <u>Nov. 14, 1968</u> <u>4:55 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> 8. COUNTY <u>15-02</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Franklin Square Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		E. STREET AND NUMBER <u>105 N. Carey St</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>68</u>	9. AGE (in years, last birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>1577.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CARCINOMA OF PANCREAS</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. <u>157X</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 10, 1968</u> to <u>Nov. 14, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov. 14, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Hyung Kon Lee, M.D.</u>				23B. DATE SIGNED <u>Nov. 14, 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>Hyung Kon Lee, M.D.</u>		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>11-19-68</u>		24B. DATE <u>11-19-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>MORTUARY SERVICE - BCHD</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 22 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbairn</u>	
25C. FUNERAL DIRECTOR ADDRESS		25D. FUNERAL DIRECTOR ADDRESS			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11697

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH F. BERRY

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 16, 1968

11:35 P.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 16, 1968

11:35 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

MAY 28 1930

10. AGE (In years
lost birth day)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1010 Shellbanks Road

11. BIRTHPLACE (State or foreign country)

N. Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

WILLIAM BROWN

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

UNEMPLOYED

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

LENA BERRY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

219-40-0242

18. INFORMANT

RUBY BERRY

ADDRESS

1010 Shellbanks Rd.

19.

E965X I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Gunshot wound of abdomen

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E981X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

tavern

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

118 Balnew Street (Adams Cocktail Lounge)

22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

11-16-68 10:20 P.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot in tavern

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 17, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

NOV. 22 68

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem

24D. LOCATION (City, town, or county)

Ann Arundel Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 22 1968

25B. NAME OF REGISTRAR

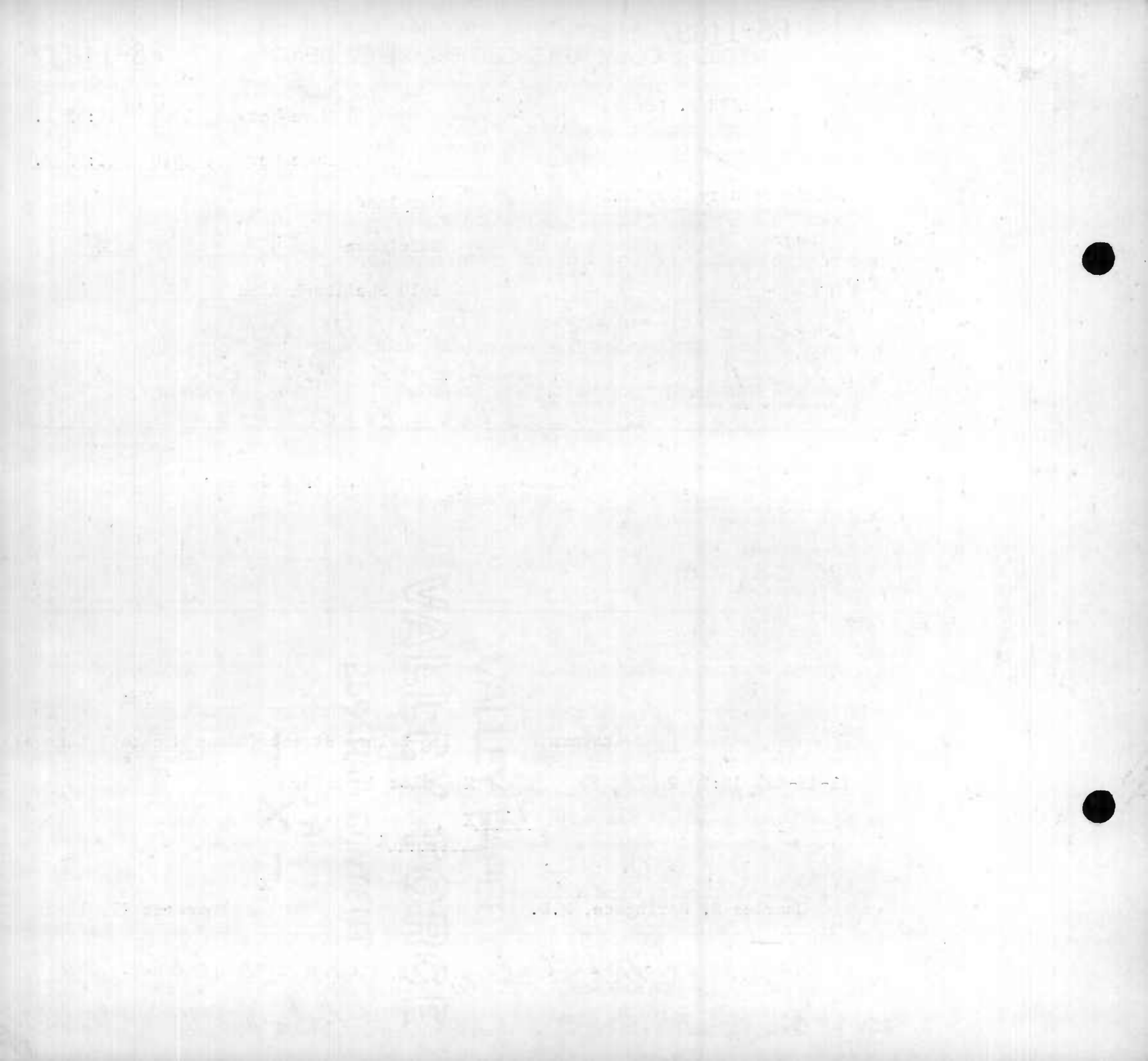
R. E. Farnham

25C. FUNERAL DIRECTOR

Joseph A. Locks Jr.

ADDRESS

1304 N. Central Ave.



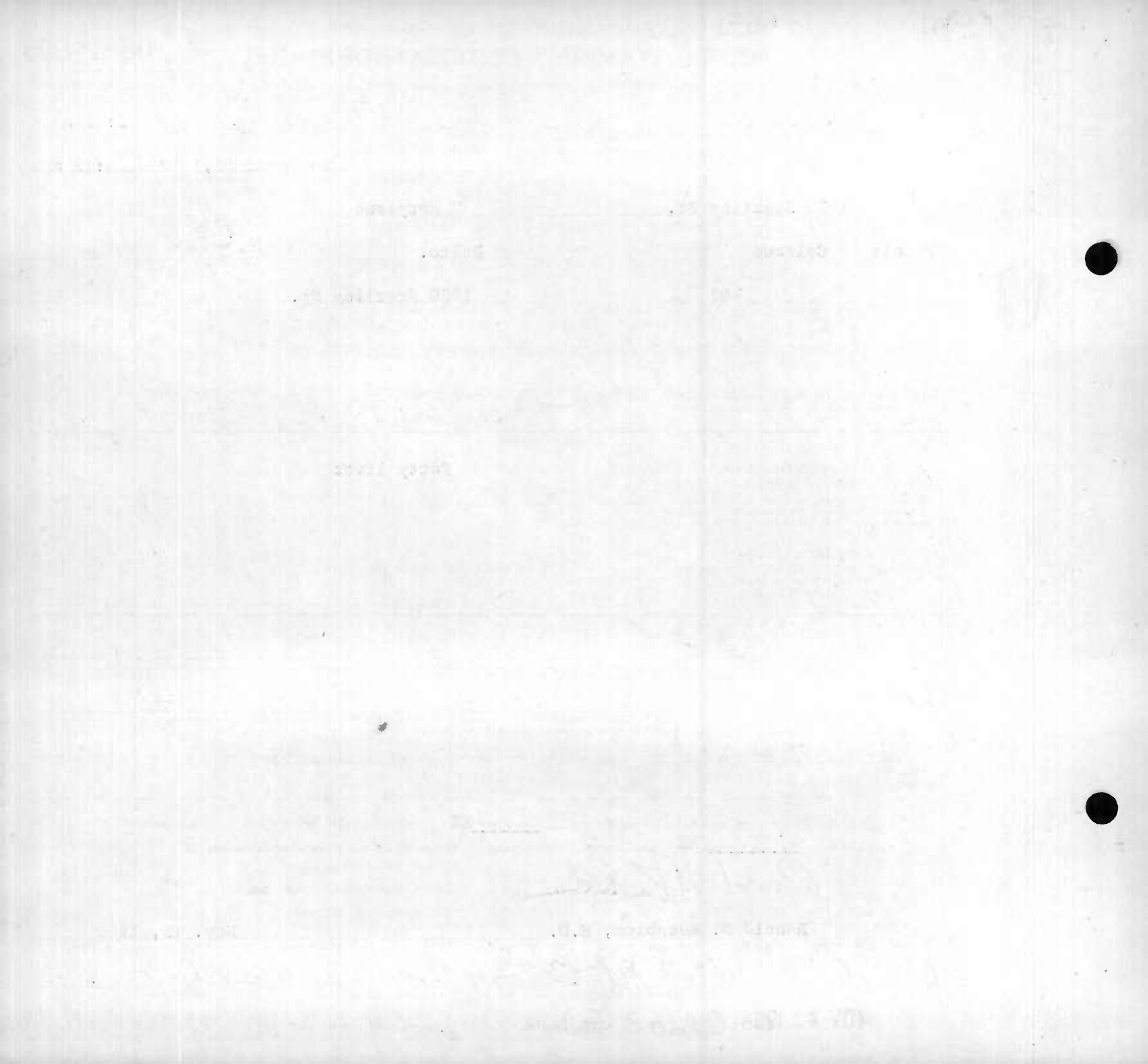
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11698

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HELEN JOHNSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 15 68 5:45 a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1020 Sterling St.		3. DATE PRONOUNCED DEAD Month Day Year Hour November 15, 1968 5:45 a M.	
6. SEX Female		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto.	
7. RACE Colored		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Month Day Year 4 0 ?		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 40?		E. STREET AND NUMBER 1020 Sterling St.	
11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ?		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		15. MOTHER'S MAIDEN NAME ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. ?	
18. INFORMANT HAywood Linehart		ADDRESS Seller Rd. Box 283	
19. 5-7-1-8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ?		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ?	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ?		(B) DUE TO, OR AS A CONSEQUENCE OF: ?	
22. (C) DUE TO, OR AS A CONSEQUENCE OF: ?			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED ?	
21. AUTOPSY? (Yes or No) YES			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? ?		22D. TIME OF INJURY (Approx.) Month Day Year Hour ?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? ?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 21, 1968	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Ann Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Joseph G. Lock Jr.		ADDRESS 13047 Central Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X	68-11699
BIRTH NO. 68-22334		68-11699 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) KATHERINE LOU COLE		2. DATE AND HOUR OF DEATH 11/19/68 6:07 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY CHARLES			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND 38 Hosp.		C. CITY OR TOWN WALDORF		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE CAUC.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY NONE		8. DATE OF BIRTH 11/17/68	
13. FATHER'S NAME WARREN C. COLE		14. MOTHER'S MAIDEN NAME BETTY JO MOORE		9. AGE (In years last birthday) 7	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOSPITAL RECORD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 769.1 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIORESPIRATORY ARREST (B) ASPIRATION (C) 7 HRS.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 769.1 II		19A. DATE OF OPERATION 2			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PRENATAL OF DIABETIC MOTHER		20A. AUTOPSY? (Yes or No) Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/17 19 68 to 11/19 19 68 , that (I) (we) last saw the deceased alive on 11/19 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theodore Wolff, M.D.		23B. DATE SIGNED 11/19/68		23C. PHYSICIAN'S NAME (Type) THEODORE WOLFF	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-21-68		24C. NAME OF CEMETERY OR CREMATORY Cedarville Full Gospel Brandywine Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR D. P. & J. R. ...		25C. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf Md.	



w-625

68-11700 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11700

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

EDWIN

E. WAWRZYNIAK

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

November 19, 1968

10:45 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CITY HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 19, 1968

10:45 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

White

B. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12-30-1920

10. AGE (In years
lost birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

6711 Railway Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Alexander Wawrzyniak

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sadie McGlockin

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

WW II

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Pauline O. Wawrzyniak 6704 German Hill Rd

19. 412.4 I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.422.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 19, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-22-68

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 22 1968

25B. NAME OF REGISTRAR

Robert E. Farkas

25C. FUNERAL DIRECTOR

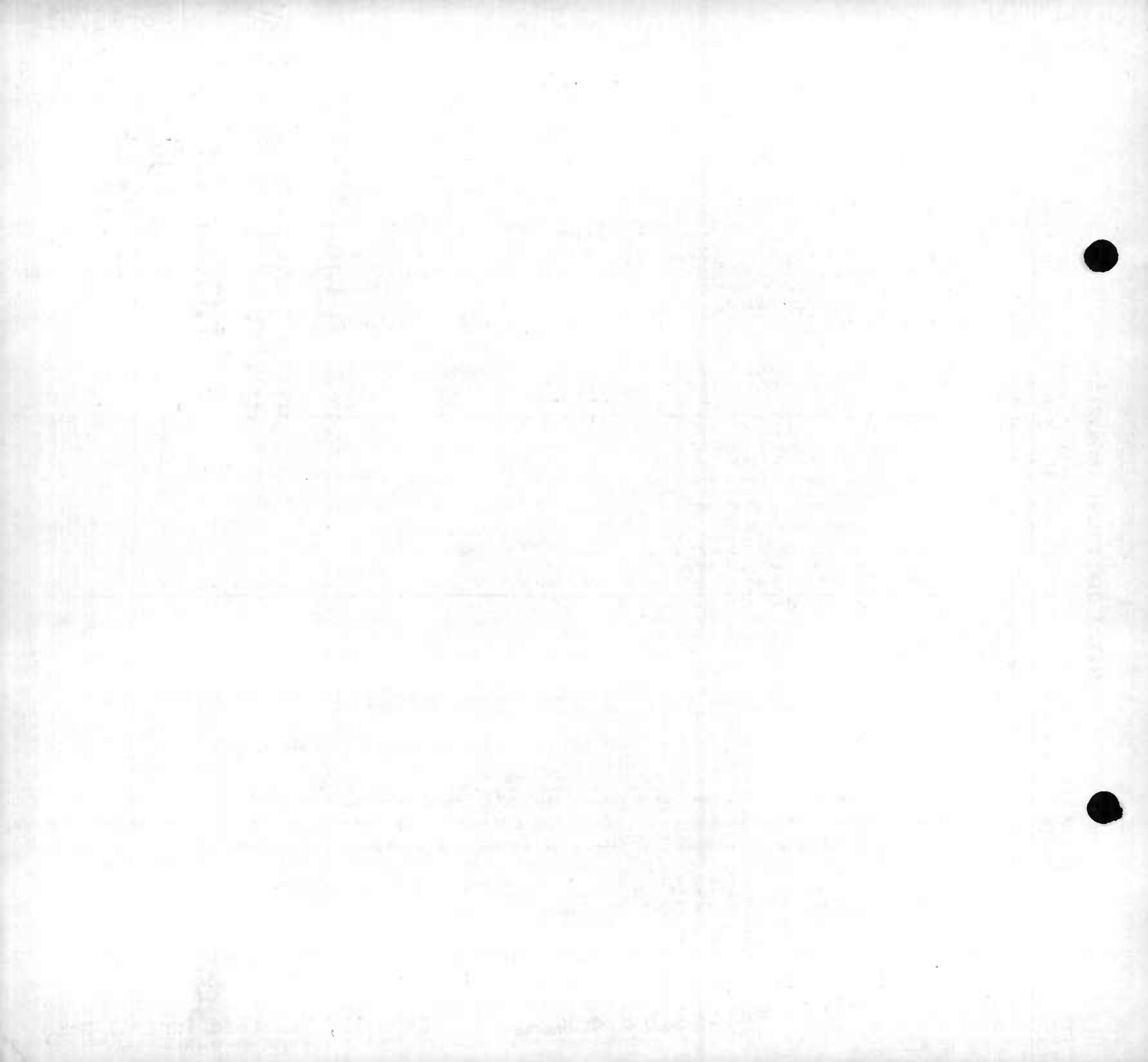
ADDRESS

WALTER DABROWSKI 1005 DUNDALK AVENUE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
68-11701		68-11701		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>James Williams</u>		2. DATE AND HOUR OF DEATH <u>Nov 20/68 9-05 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>4-02</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Century Home, Inc</u> <u>102 N. Paca St ①</u>		E. STREET AND NUMBER <u>102 N Paca St</u>			
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/3/88</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Junk Collector & Navigator</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>?</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>229-10-1999</u>		17. INFORMANT <u>MRs Elsie Williams</u> ADDRESS	
18. <u>150X I</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Esophagus</u> <u>Cardio Respiratory Failure</u> <u>Arteriosclerotic CVD</u> <u>Malnutrition</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <u>150X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>11/2/68</u> 19 to <u>11/20/68</u> 19		that (I) (we) last saw the deceased alive on <u>11/20/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Willard Appleberry</u> DEGREE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Willard Appleberry</u> DEGREE	
23D. ADDRESS <u>6615 Rustington Rd</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/24/68</u>	
24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		25A. DATE RECEIVED <u>NOV 22 1968</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>I Carroll</u>		ADDRESS <u>Halstead Funeral Home</u> <u>1206 W North Ave</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11702

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRY DAVID NELSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> November 19, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour November 19, 1968 M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Fountain Inn	
9. DATE OF BIRTH 6/7/1918		10. AGE (In years last birthday) 50	
11. BIRTHPLACE (State or foreign country) Greenville, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claude Nelson		14. MOTHER'S MAIDEN NAME Rosa Peden	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) World War II		18. SOCIAL SECURITY NO. 250-17-5423	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
22A. DATE OF OPERATION 2		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22E. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22G. HOW DID INJURY OCCUR?		23. AUTOPSY? (Yes or No) yes	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		DATE SIGNED November 19, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/23/68	
24C. NAME OF CEMETERY or CREMATORY Greenville		24D. LOCATION (City, town, or county) (State) Greenville, S.C.	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Wm. J. Tickner		25D. ADDRESS Baltimore, Md.	

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11703 CERTIFICATE OF DEATH

REG. NO. 68-11703

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Jacob Foutz</u>		2. DATE AND HOUR OF DEATH <u>11-19-68</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>15-10</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 Cole's Boarding Home.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4012 Maine Ave.</u>		C. CITY OR TOWN <u>Balt.</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>4012 Maine Ave.</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/16/1888</u>	9. AGE (In years lost birthday) <u>80</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Coles Boarding Home - 4012 Maine Ave</u>	
18. <u>410.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Occlusion</u> (B) <u>Arterio-sclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Hypertensive card-vasc. Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>Unknown</u> <u>Unknown</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u>		<u>Chronic Brain Syndrome</u>		<u>Unknown</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/25</u> 19 <u>67</u> to <u>11/19</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/16</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. F. Holt</u>				23B. DATE SIGNED <u>11/19/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. F. Holt M.D.</u>				23D. ADDRESS <u>3715 Liberty Hgts. Ave. Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/20/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven</u>	
				24D. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 22 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbanks</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Tichner Sons Balt., Md.</u>	



B-650

68-11704 BALTIMORE CITY HEALTH DEPARTMENT

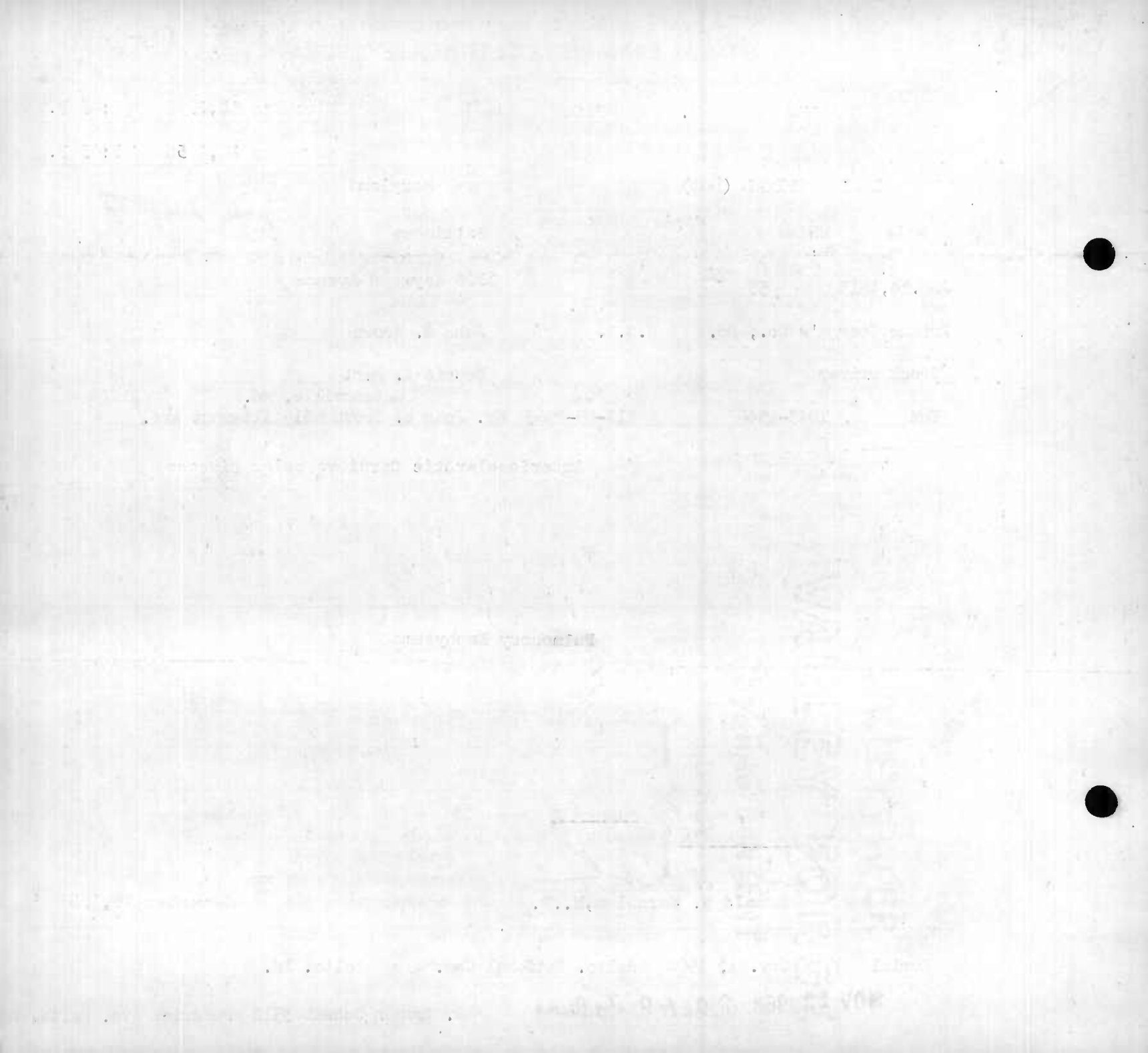
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11704

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) CHARLES T. BROWN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 18, 1968 Hour 7:45 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL (DOA) (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year November 18, 1968 Hour 7:45 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Jan. 14, 1913		10. AGE (In years last birthday) 55	
11. BIRTHPLACE (State or foreign country) Prince George's Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Brown		14. STREET AND NUMBER 3308 Haywood Avenue	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		15. MOTHER'S MAIDEN NAME Bessie A. Hart	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1943-1946		17. SOCIAL SECURITY NO. 217-05-2563	
18. INFORMANT Mr. John E. Brown 6616 Altamont Ave.		ADDRESS Catonsville, Md. 21228	
19. CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pulmonary Emphysema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 4/22/11		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 19, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 21, 1968	
24C. NAME OF CEMETERY or CREMATORY Balto. National Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR R. E. F. F. F.	
25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md.		ADDRESS	

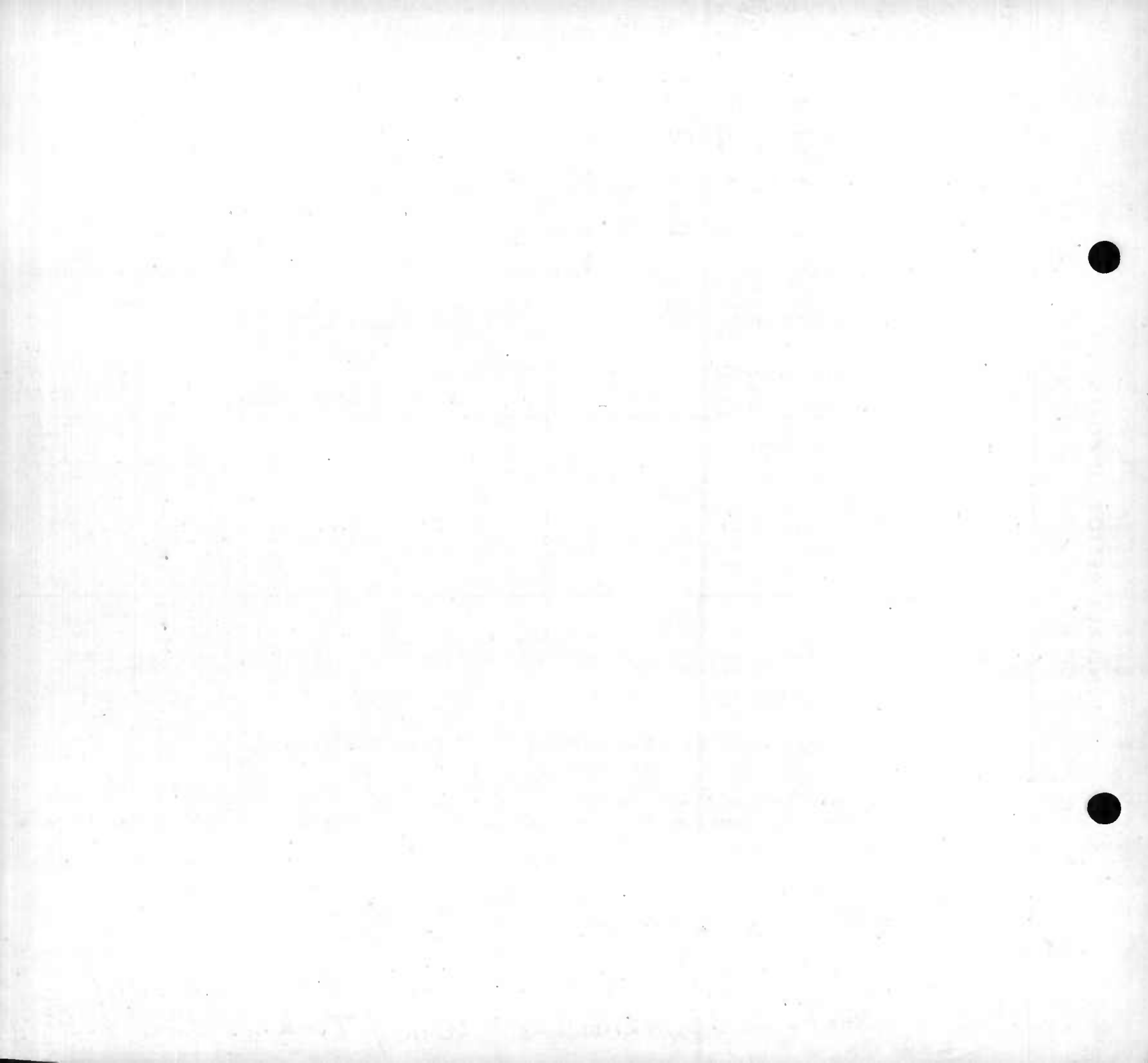


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11705 CERTIFICATE OF DEATH

REG. NO. 68-11705

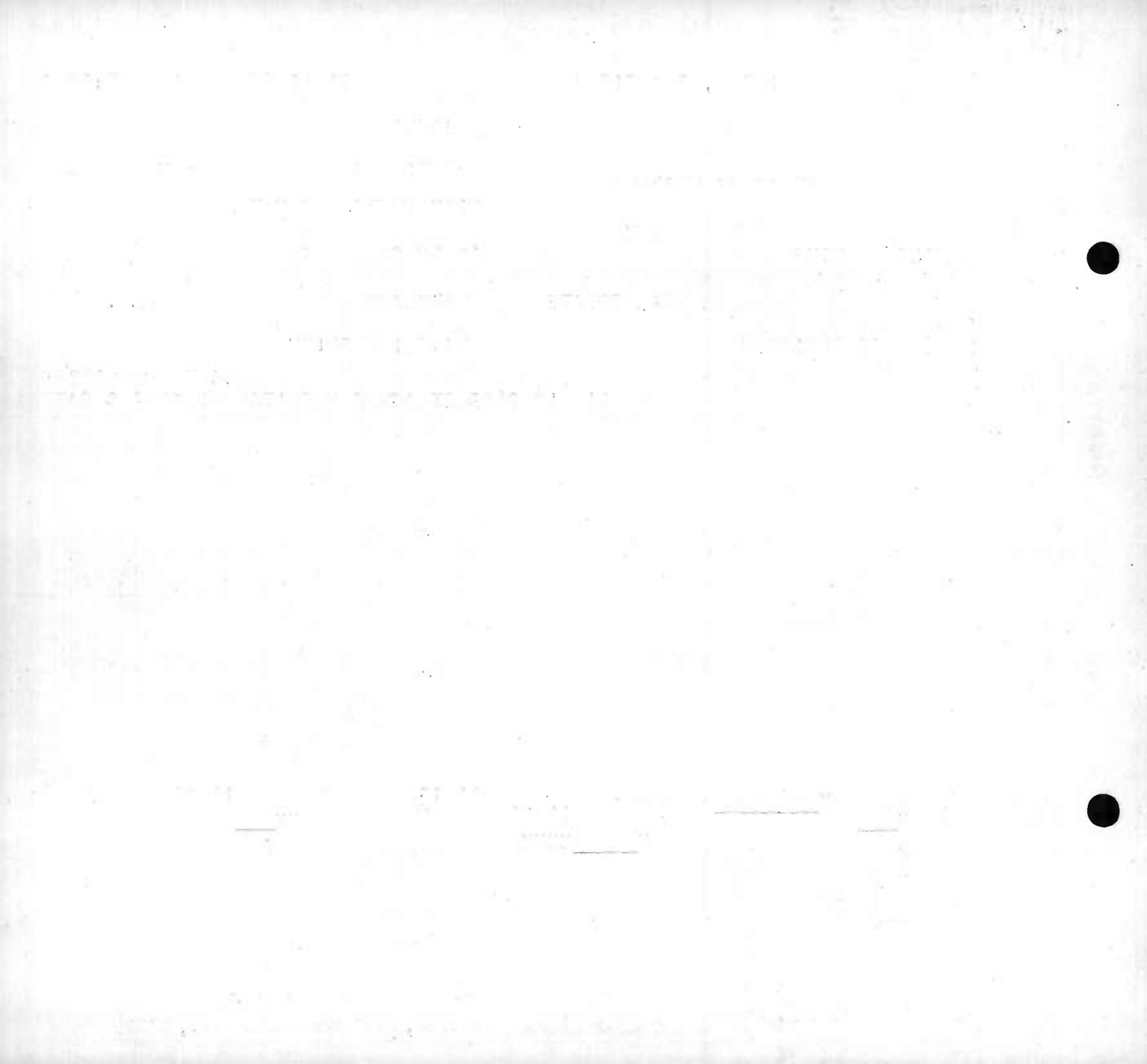
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		STANLEY KUSMIERSKI		12:40 PM 11/12/68 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
BOLTON HILL NURSING & CONVAlescent Ctr				Md. C. CITY OR TOWN D. INSIDE CITY LIMITS?	
10				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				1400 W. Lafayette Ave.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5/2/93	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				POLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
UNKNOWN			UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
UNKNOWN			212-10-6647		MEDICAL RECORDS BOLTON HILL (AS ABOVE)
18. CAUSE OF DEATH					
410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction Several minutes					
(B) DUE TO, OR AS A CONSEQUENCE OF: Anteromedial Heart Disease Unknown					
(C).....					
4201.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): Paraplegia due to spinal cord lesion 6 yrs					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				N	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from March 11 19 68 to Nov. 12 19 68, that (I) (we) last saw the deceased alive on Nov. 11 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Roland T. Smoot, M.D.				11/12/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ROLAND T. SMOOT, M.D.				3817 Gay Rd., Balt 15, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/14/68		Glen Haven Cem.	
				Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 22 1968		Robert E. Fairburn		Wm. J. Tichner & Son, Balt., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 152	68-11706	68-11706
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
		ROBINSON, FRANCIS R		11 21 68		7:35 A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL			A. STATE MARYLAND			
			B. COUNTY Baltimore 53-00			
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER 7105 IVERSON COURT			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 20 09	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME E ROSS ROBINSON				14. MOTHER'S MAIDEN NAME MADELINE SMITH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218 10 34		17. INFORMANT BALTO MD 21229 ADDRESS 403 ST AGNES HOSPITAL WILKENS & CATON		
18. 436.0 I CAUSE OF DEATH						
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Vascular Accident unknown</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.						
(B) <i>HYPERTENSIVE</i> DUE TO, OR AS A CONSEQUENCE OF:						
(C) _____						
19. 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11 17 68 to 11 21 68, that (I) (we) lost saw the deceased alive on 11 21 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
23A. SIGNATURE <i>James H. Hargis, M.D.</i>				23B. DATE SIGNED 11/21/68		
23C. PHYSICIAN'S NAME (Type) St/ Agnes Hospital				23D. ADDRESS St/ Agnes Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/25/68		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE RECEIVED BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR <i>Robert E. Tully</i>		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11707

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11707

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CARROLL S. KIRBY		2. DATE AND HOUR OF DEATH Nov. 19, 1968 4⁰⁵ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL 33 RD & CALVERT STS.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 13-06 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER W. 36TH ST	
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/28/94	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10B. KIND OF BUSINESS OR INDUSTRY Glen Martin Co.		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George W. Kirby			
14. MOTHER'S MAIDEN NAME Mary Burns		15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) No N/A			
16. SOCIAL SECURITY NO. 216-12-7966		17. INFORMANT Mrs. Lola Kilmon, 2910 Cresmont Ave. - 11-			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Y.S.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 11/18 19 68 to 11/19 19 68 , that (1) (we) last saw the deceased alive on 11/19 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald M. Legum M.D.		23B. DATE SIGNED 11/19/68		23C. PHYSICIAN'S NAME (Type) RONALD M. LEGUM	
23D. ADDRESS UNION MEMORIAL HOSPITAL BALT. MD		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11-23-68		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Pk		24D. LOCATION (City, town, or county) (State) Parkville, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Jarboe		25C. FUNERAL DIRECTOR William Smith Jr.	
25D. ADDRESS 814 W. 36th St. 21211					

121

to receive Glen Martin Co

George W. Kelly

Harry Evans

Mr.

an is-are Mr. L. K. Evans

Book 11-22-23 Michael Thomas M. Parkville, Mo.

March 24th 1894

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

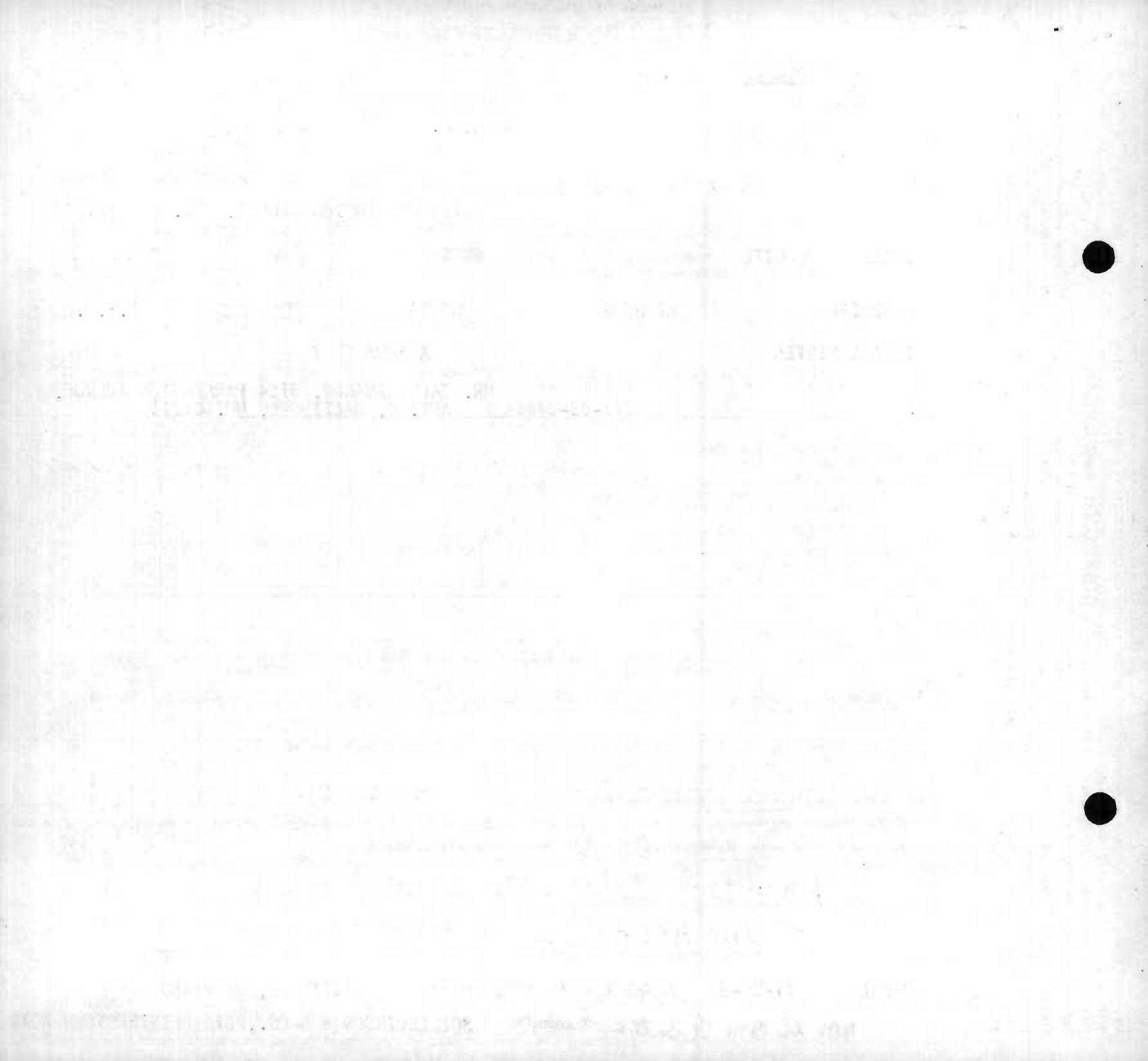
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**BALTIMORE CITY HEALTH DEPARTMENT
68-11708 CERTIFICATE OF DEATH**

REG. NO.

68-11708

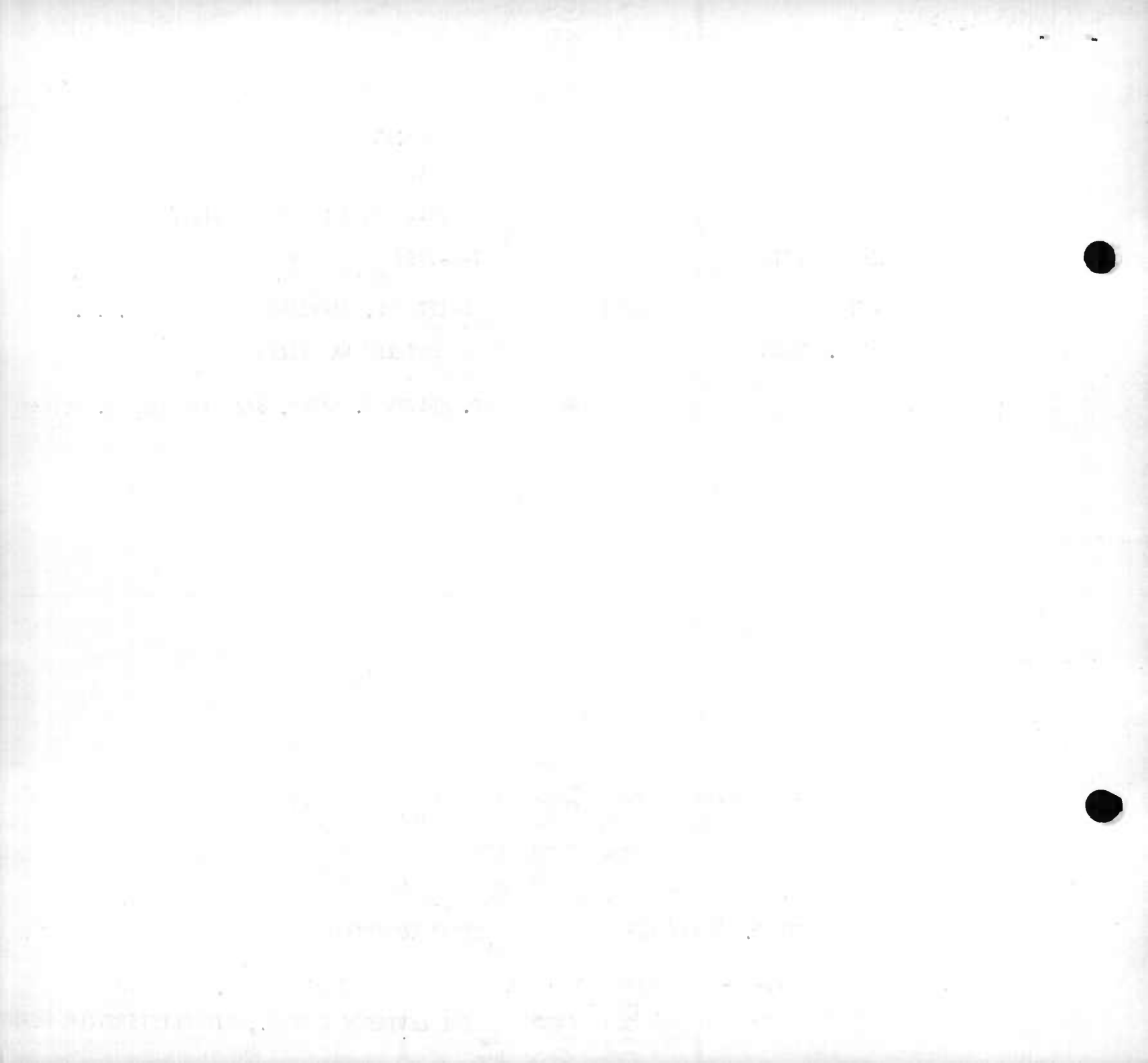
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FANNIE ASCH		2. DATE AND HOUR OF DEATH 11-19-68 9.05 a M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION LEVINDALE HEBREW HOME & INFIRMARY 91			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3124 PARKINGTON AVENUE, APT. C #21215		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-88	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ISRAEL WINTER		14. MOTHER'S MAIDEN NAME X ANNA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-03-6488A		17. INFORMANT ADDRESS MR. JACK WINAKUR, 3124 PARKINGTON AVENUE, APT. C, BALTIMORE, MD. 21215	
18. 480X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia 3 wks (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. 491X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-14-1958 to 11-19-68 19____, that (I) (we) last saw the deceased alive on 11-19-68 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Arday			23B. DATE SIGNED 11-19-68		
23C. PHYSICIAN'S NAME (Type) Jose ARDAY			23D. ADDRESS 7 OBERLIN COURT Towson, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-20-68		24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH AITZ CHAIM	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968			
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

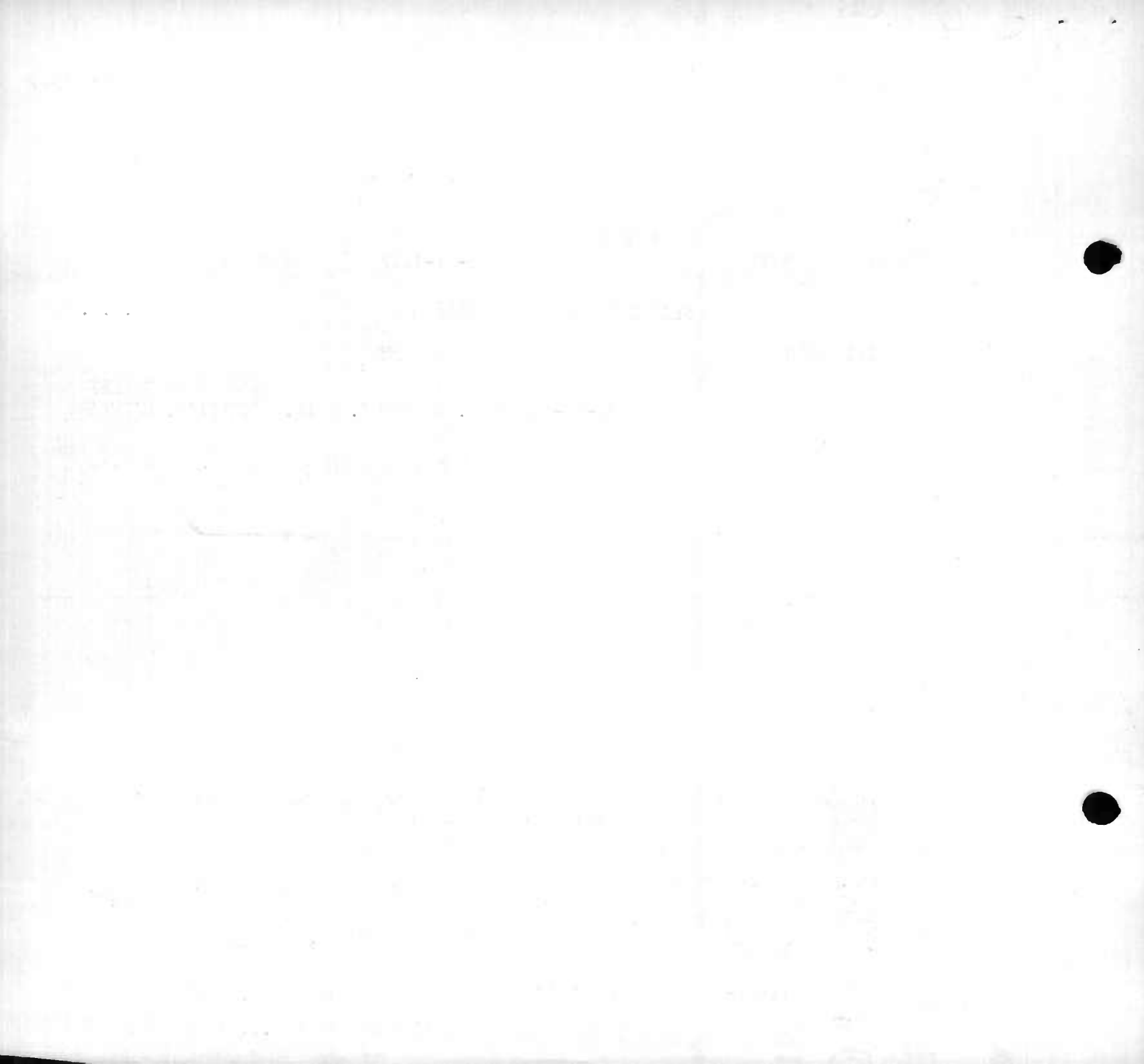
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X	68-11709
BIRTH NO.			68-11709 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ELLEN MICHELE MARKS			NOV 21, 1968 4 ⁵⁵ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
SINAI HOSPITAL			MARYLAND Baltimore 53.00		
42			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
BALTIMORE			YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			3422 JANVALE ROAD #21207		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-7-1959	9	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
STUDENT		SCHOOL		BALTIMORE, MARYLAND	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
MELVIN P. MARKS			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO			NO		MR. MELVIN P. MARKS, 3422 JANVALE RD. #21207
18. 207.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			leukemia, acute 3yr. 6mo.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
204.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/14 1968 to 11/21 1968, that (I) (we) last saw the deceased alive on 11/21 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Keith R. McCloskey M.D.				11/21/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
KEITH R. MC CLOSKEY				SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11-22-68		BALTIMORE HEBREW	
24D. LOCATION		24E. LOCATION		24F. LOCATION	
REISTERSTOWN, MARYLAND		REISTERSTOWN, MARYLAND		REISTERSTOWN, MARYLAND	
25A. DATE RECEIVED		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 22 1968		Robert E. Jenkins, Jr.		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11710
BIRTH NO. 1400		1. NAME OF DECEASED (Type or Print) William CHAIM Cole		2. DATE AND HOUR OF DEATH Nov. 19, 1968 10:25 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-19		
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHOTO		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		8. DATE OF BIRTH 5-21-1887
13. FATHER'S NAME PHILIP COHEN		11. BIRTHPLACE (State or foreign country) RUSSIA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-10-6667A		12. CITIZEN OF WHAT COUNTRY? U.S.A.
17. INFORMANT MR. EDWARD S. COLE, ROCKVILLE, MARYLAND		ADDRESS 4804 EADES STREET		
18. 43619 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident 6 days		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION 0		20. AUTOPSY? (Yes or No) No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from Nov. 13 19 68 to Nov 19 19 68 , that (I) (we) last saw the deceased alive on Nov. 19 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Barton A. Cohen		23B. DATE SIGNED 11/19/68		23C. PHYSICIAN'S NAME (Type) Barton A. Cohen
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-21-68		24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-11711	
68-11711 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Z. GEORGE [REDACTED] EPSTEIN		2. DATE AND HOUR OF DEATH 11/20/68 6 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-13			
FULL NAME OF HOSPITAL OR INSTITUTION BELVEDERE NURSING HOME 2525 W. BELVEDERE AVENUE		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY TRADING POST		8. DATE OF BIRTH 10-20-1898 9. AGE (In years last birthday) 70	
11. BIRTHPLACE (State or foreign country) PROVIDENCE, R. I.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HERMAN EPSTEIN		14. MOTHER'S MAIDEN NAME LENA SHEIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. LOUIS SILVERSTEIN 10 LIGHT ST. #21202	
18. 1835-X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) HEPATIC FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 14K (B) DUE TO, OR AS A CONSEQUENCE OF: 1 YR (C) CARCINOMA OF PROSTATE 5 YRS		CAUSE OF DEATH HEPATIC FAILURE 14K 1 YR 5 YRS			
177X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION ONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1967 19 to 11/20 19 68 , that (1) (we) last saw the deceased alive on 11/19 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (view) the body after death.					
23A. SIGNATURE Bernard R. Shochet, M.D.				23B. DATE SIGNED 11/20/68	
23C. PHYSICIAN'S NAME (Type) BERNARD SHOCHET				23D. ADDRESS 6804 PARK HEIGHTS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL-BURIAL		24B. DATE 11-22-68		24C. NAME of CEMETERY or CREMATORY TEMPLE EMANUEL	
24D. LOCATION (City, town, or county) (State) ROANOKE, VIRGINIA		25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968			
25B. NAME OF REGISTRAR Robert E. [REDACTED]		25C. FUNERAL DIRECTOR ADDRESS John [REDACTED] 6016 [REDACTED]			

PAGE WHITE



NEUTRAL FAILURE

NEUTRALISTIC CRACKING

CASEWORK OF FUTURE

NO

W-4E

leaf

W/M



General Review

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

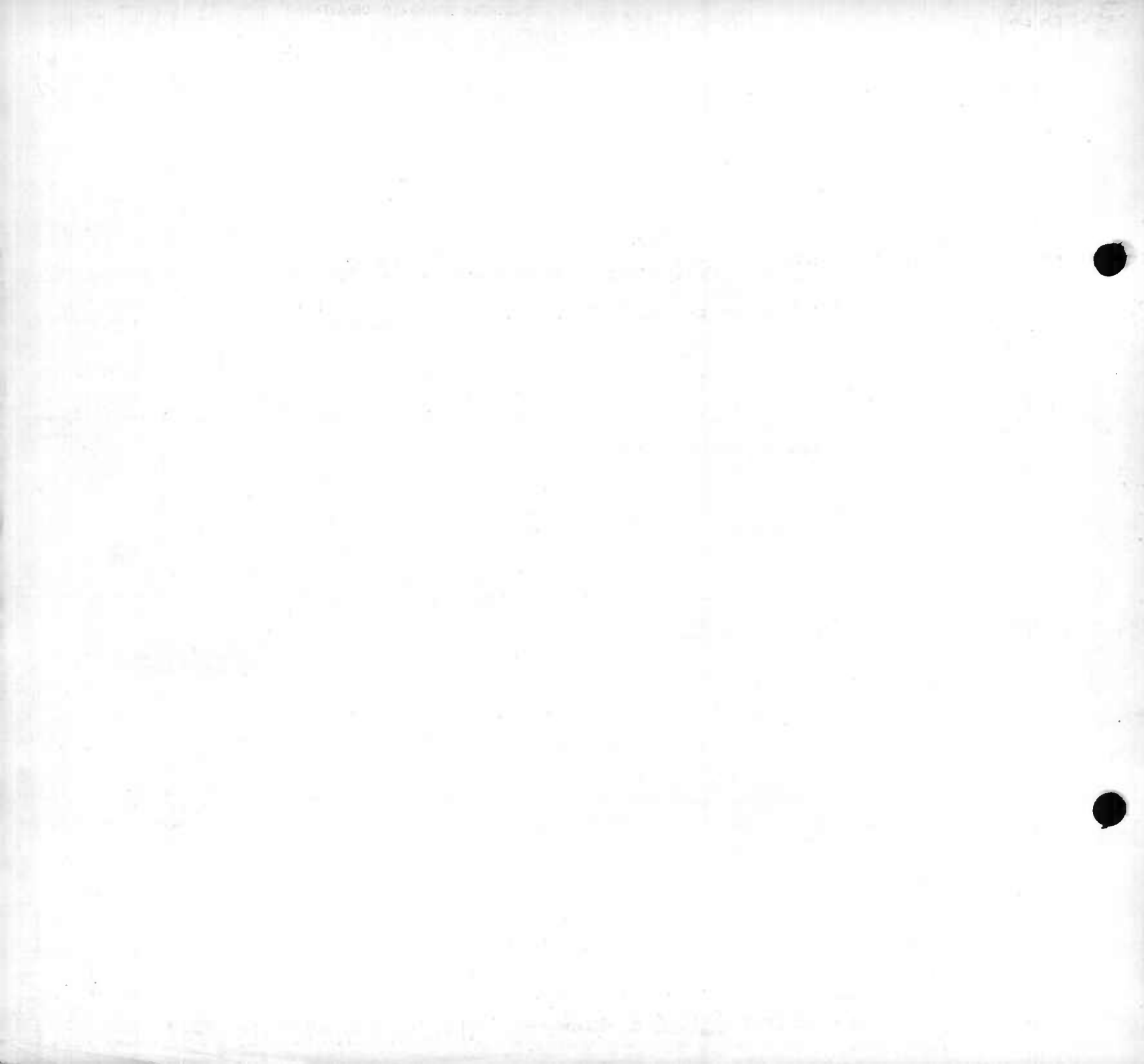
68-11712

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11712

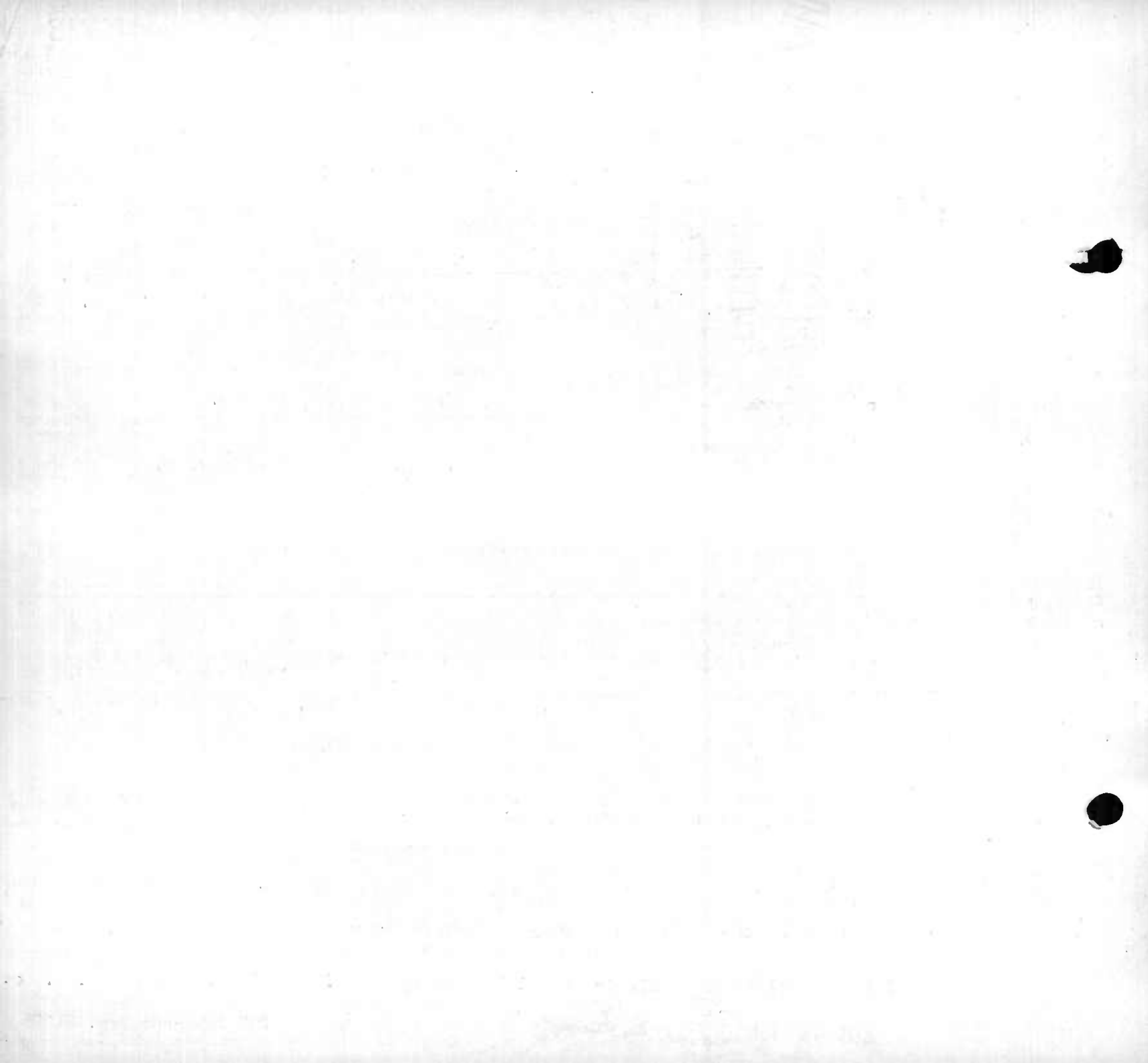
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIE ROESZIES		2. DATE AND HOUR OF DEATH NOVEMBER 19, 1968 10:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 19-03	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND HOSPITAL 38		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1521 W. LOMBARD STREET	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1913		9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MAINTENANCE GAS & ELECTRIC CO.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? GERMANY		13. FATHER'S NAME CRISTOFF ROESZIES		14. MOTHER'S MAIDEN NAME MARIA ROESZIES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. GERMAN ARMY W# 217-38-2961		17. INFORMANT EDITH ROESZIES	
				ADDRESS AS ABOVE	
18. 157.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF: OF BODY OF PANCREAS (B) POSTOPERATIVE GI BLEEDING DUE TO, OR AS A CONSEQUENCE OF: (C) (STRESS ULCERS)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
157X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION OCT. 31, 1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED OBSTRUCTIVE JAUNDICE		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT. 21 19 68 to NOV. 19 19 68 , that (I) (we) last saw the deceased alive on NOV. 19 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Consolador E. Palad, Jr., M.D.				23B. DATE SIGNED 11-19-68	
23C. PHYSICIAN'S NAME (Type) CONSOLADOR E. PALAD, JR., M.D.		23D. ADDRESS UNIVERSITY OF MARYLAND HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-22-68		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR WALTERS FUN'L HOME PRATT & STRICKER	
				ADDRESS ST. 5	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X	68-11713
<div style="display: flex; justify-content: space-between;"> B-6212 68-11713 CERTIFICATE OF DEATH 68-11713 </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Roland Broseker		11/19/68 6 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
			A. STATE B. COUNTY		
			Md - Anne Arundel Co 52-00		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
South Baltimore General Hospital			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
4.3			E. STREET AND NUMBER		
			211 6th Ave Brooklyn Park 21225		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6-6-88	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Electrician Contr. Electrical			Maryland		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
unknown			unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No No				admission sheet	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
410.9 I					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Myocardial Infarction 4 days		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10:15 AM 11-17 19 68 to 6 PM 11-19 19 68, that (I) (we) last saw the deceased alive on 6 PM 11-19 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
C. G. BAUMANN				11-19-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
C. G. BAUMANN M.D.				South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/22/68		Baldwin Memorial Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Millersville, Maryland A. A. Co.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 22 1968		Robert E. Tarkenton		237 Patapsco Ave. 21225	



F-640

68-11714 BALTIMORE CITY HEALTH DEPARTMENT

68-11714

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROSE FARRELL		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 13 68 9:30a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2332 E. Fayette St. D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour November 13, 1968 9:00a	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Feb. 25, 34		10. AGE (In years last birthday) 34	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF White	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY -	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) -		17. SOCIAL SECURITY NO. -	
18. INFORMANT Dorothy Marrone New York		ADDRESS 116-02-108 A	
19. 490 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Car pulmonary		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Drunk	
20A. DATE OF OPERATION 5-01 X II		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED -	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -		22D. TIME OF INJURY (Approx.) -	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? -	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson		M.D.	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/16/68	
24C. NAME OF CEMETERY or CREMATORY New Catholic		24D. LOCATION (City, town, or county) (State) New Catholic Cem.	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Tarkenton	
		25C. FUNERAL DIRECTOR T. Fisher - 1930 Eastern Ave	

1000
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1000

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J-635

68-11715 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11715

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY JORDAN W. Jordan		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 18 68 6:50 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 11-25-68		3. DATE PRONOUNCED DEAD Month Day Year Hour November 18, 1968 6:50 a.m.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH April 20, 1906		10. AGE (In years lost birthday) -63-62	
11. BIRTHPLACE (State or foreign country) Wilmington, Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Maid		14B. KIND OF BUSINESS OR INDUSTRY Collington Cafe	
15. MOTHER'S MAIDEN NAME Carrie Martin		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 214-22-0706		18. INFORMANT Milton A. Jordan	
19. CAUSE OF DEATH E812.1 I		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Injuries	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E816.4 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2300 Bl. Belair Rd.		22D. TIME OF INJURY (APPROX.) 11 18 68 6:02 a	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject passenger in auto-auto coll.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson		M.D.	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-21-68	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Jarboe	
25C. FUNERAL DIRECTOR John C. Miller Inc.		ADDRESS 6415 Belair Rd.	

Del. B.C. from Wilmington, Del. filed
7-21-65 11-25-68 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11716 CERTIFICATE OF DEATH

REG. NO. 68-11716

BIRTH NO.		1. NAME OF DECEASED (Type or Print) David Scott Hancock		2. DATE AND HOUR OF DEATH November 19, 1968 11 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 13-25		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		E. STREET AND NUMBER 2282 Park Hill Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 11 1950	9. AGE (In years last birthday) 18	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Winfield Scott Hancock		14. MOTHER'S MAIDEN NAME Jeann Walker	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215 54 2026		17. INFORMANT Winfield S Hancock	
18. 200.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) LYMPHOSARCOMA		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: LYMPHOSARCOMA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		ADDRESS 2282 Park Hill Ave APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
19. 200.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (he) (she) attended the deceased from August 1 1968 to November 19 1968 , that (I) (we) last saw the deceased alive on November 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.					
23A. SIGNATURE Carroll L. Spurling, MD.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED November 21, 1968	
23C. PHYSICIAN'S NAME (Type) Dr Carroll L. Spurling		23D. ADDRESS University Hosp. Balto Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-22-68		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem	
24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Co MD		25A. DATE RECEIVED NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks	
25C. FUNERAL DIRECTOR Burgess Funeral Home Balto Md		25D. ADDRESS By Harold M. ...			

Thompson

August 1 1882

General

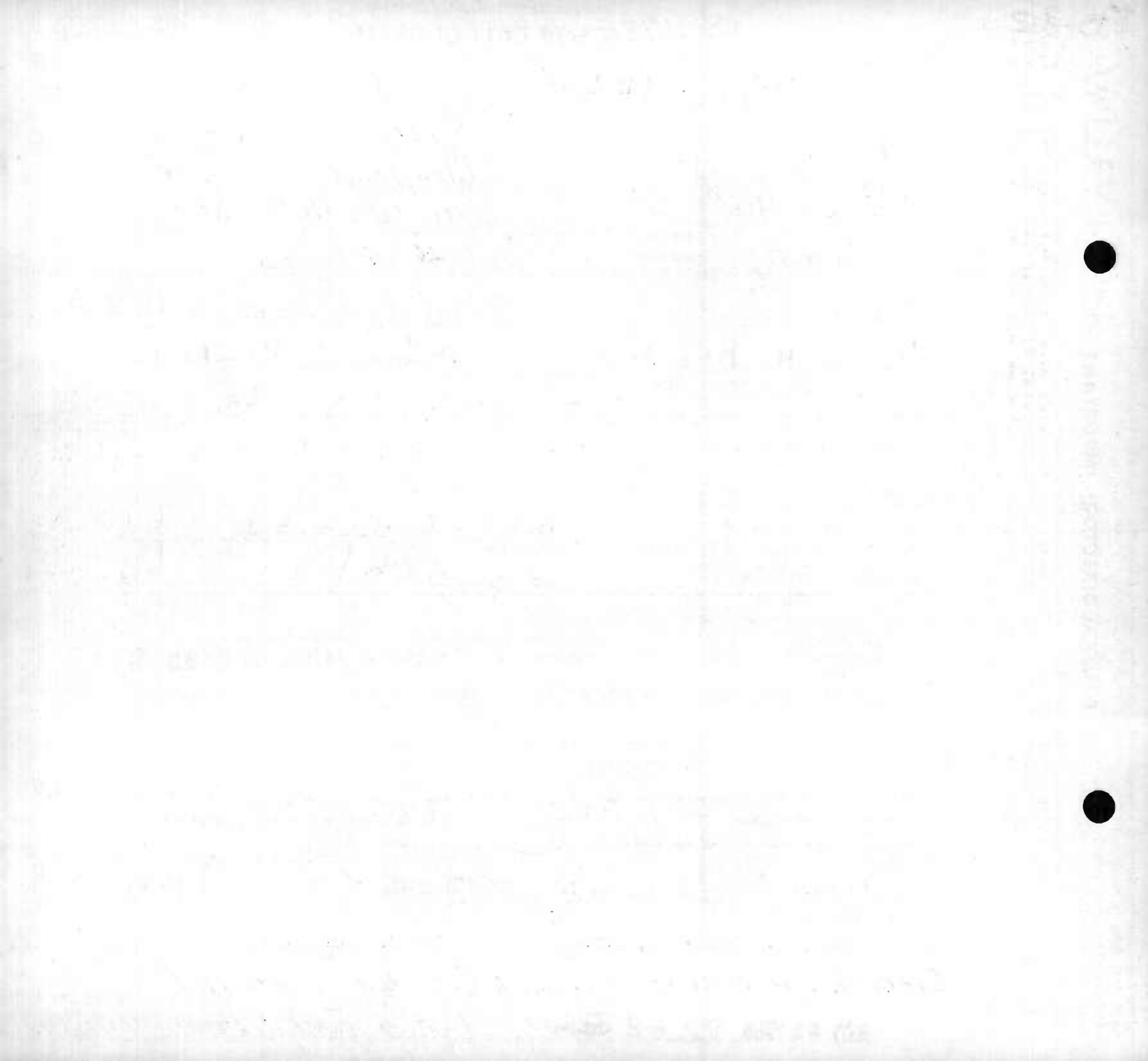
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11717 CERTIFICATE OF DEATH

REG. NO. 68-11717

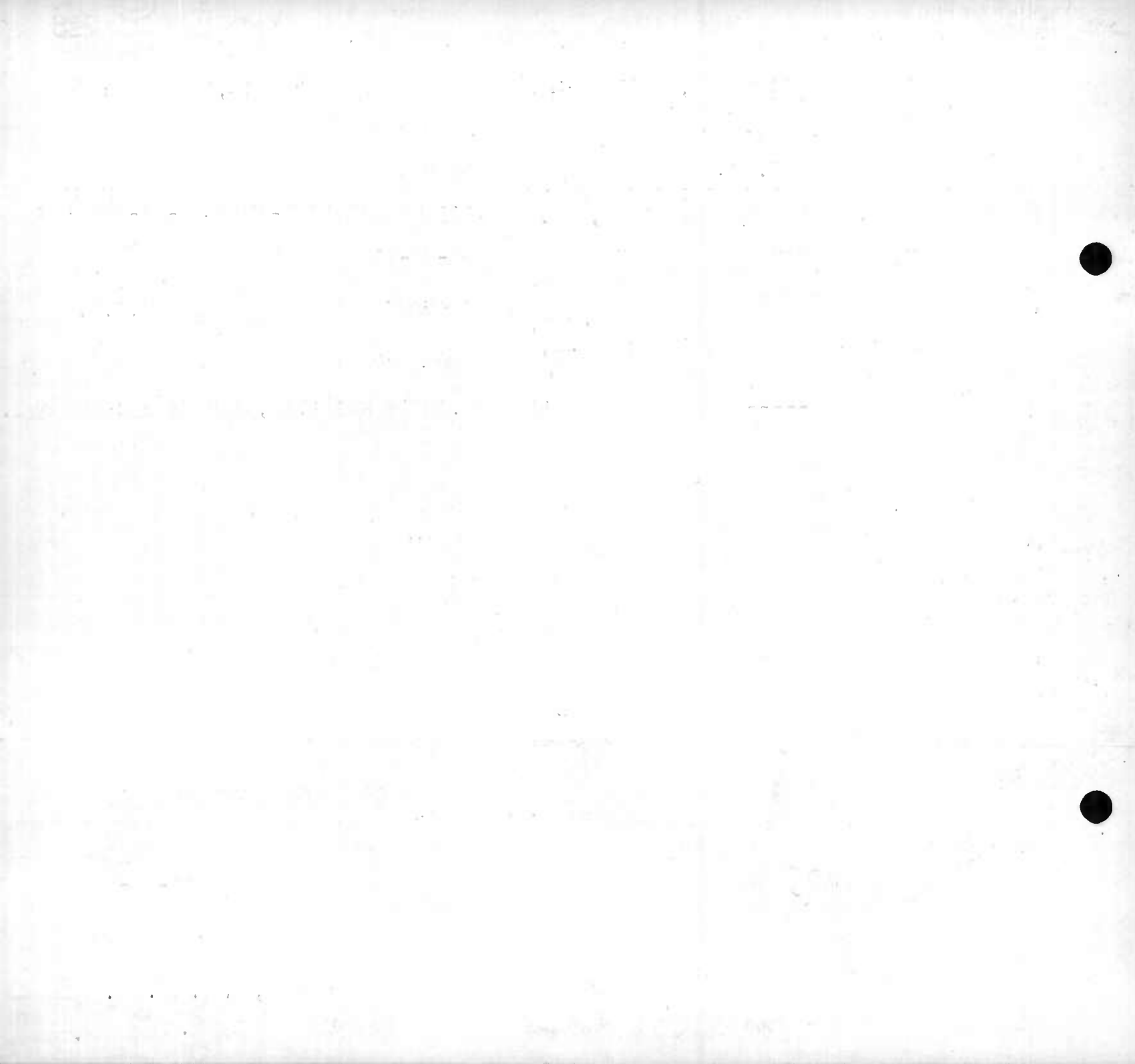
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BROCKEY, NORA MAY		2. DATE AND HOUR OF DEATH 11-19-68 1:25 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Keswick 71 700 W 40th St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Balto B. COUNTY 13-07	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Keswick				C. CITY OR TOWN Maryland D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 700 W 40th St					
5. SEX F.	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-05	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George H. Brockey			
14. MOTHER'S MAIDEN NAME Missouri Humbartson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. -		17. INFORMANT Vergie Crouch B.N. Keswick			
18. 733.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Thrombosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis cerebral		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 332X II		(B) DUE TO, OR AS A CONSEQUENCE OF: Congenital Athetosis		4 months	
(C) entire life					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 332X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 17 Dec 1968 to 19 Nov 1968 , that (I) (we) last saw the deceased alive on 19 Nov 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aubrey D. Richardson, M.D.				23B. DATE SIGNED 19 Nov 1968	
23C. PHYSICIAN'S NAME (Type) Aubrey D. Richardson, M.D.				23D. ADDRESS 700 W. 40th Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation 11-21-68		24B. DATE 11-21-68		24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery Balto Md	
24D. LOCATION Balto Md		25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Burgee Funeral Home		25D. ADDRESS Balto Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11718
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SCHERDER, ELIZABETH		NOVEMBER 19, 1968 6:40 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 21229, MD.			A. STATE MARYLAND		B. COUNTY Baltimore Co. 53-00
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 333 HARLEM LANE-SHANGRA-LA-NURSING			HOME		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-06-71	9. AGE (In years last birthday) 97	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME THEO			14. MOTHER'S MAIDEN NAME Katherine		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 220445136		
			17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH Congestive Heart Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A - see D) Gangrene of legs - (B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D. (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II			ADVANCED DIABETES MELLITUS.		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 06 19 68 to NOVEMBER 19 1968, that (I) (we) lost saw the deceased alive on NOVEMBER 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alexander Augustus			23B. DATE SIGNED 11-20-68		23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA MD
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 11 23 68		24C. NAME OF CEMETERY or CREMATORY Holy Cross
24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.			25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		
25B. NAME OF REGISTRAR Robert E. Johnson			25C. FUNERAL DIRECTOR Mc Cully		
			130 E. Fort Ave.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11719

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN W. MEYERS		2. DATE AND HOUR OF DEATH 11/20/68 4:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3808 Ridgcroft Road Baltimore, Maryland		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3808 Ridgcroft Road					
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-1882	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John E. Meyers		14. MOTHER'S MAIDEN NAME Mary M. Hubbard			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-28-5487		17. INFORMANT Anna M. Richardson 3808 Ridgcroft Road	
18. CAUSE OF DEATH 412.2.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cardio-Vascular Hypertensive Disease Anemia		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Edema (B) DUE TO, OR AS A CONSEQUENCE OF: Cardio-Vascular Hypertensive Disease (C) Anemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours 8 years 8 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443 X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 1960 to November 20 1968 , that (I) was last saw the deceased alive on Oct. 24 1968 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Michael J. Dausch M.D.		23B. DATE SIGNED 11/21/68			
23C. PHYSICIAN'S NAME (Type) Michael J. DAUSCH M.D.		23D. ADDRESS 4636 Belair Road Balt. Md. 21206			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-21-1968		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. 1050 York Road 21204	

William G. Adams

Chief Clerk of the House of Representatives

Washington, D.C.

Dec 21 1892

✓

Mr. J. P. Jones

U.S. District Court

U.S. District Court

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11720

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EZRA WEAVER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 11 19 68 6:46 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour November 19, 1968 6:46 p.m.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Sep. 28, 1893		10. AGE (In years lost birthday) 72 75	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		14B. KIND OF BUSINESS OR INDUSTRY Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No N/A		17. SOCIAL SECURITY NO. 215-07-6444	
18. INFORMANT Mr. Melvin Rowley, 3026 Darby St.		ADDRESS 21211	
19. 42.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE UNKNOWN bronchopneumonia, left lung, emphysema (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Edward F. Wilson</i> M.D. EXAMINER'S NAME (Type): Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: November 20, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 22, 1968	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Jarboe	
25C. FUNERAL DIRECTOR A. Alan Seitz, Jr.		ADDRESS 814 W. 36th St.	

WALL 11/15/71 150111ms11

5/6/72 CON 15441

Blind for

Edward J. Wilson, Jr.

2-11-72 11/15/71 150111ms11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11721 CERTIFICATE OF DEATH

REG. NO. 68-11721

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WALKER L. REASER

2. DATE AND HOUR OF DEATH

11:10 am 11/17/68

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

407 S. BONSALE ST (24)

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5-26-97

9. AGE (In years
last birthday)

71

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

BETH STEEL CO.

11. BIRTHPLACE (State or foreign country)

GLENNVILLE, W. VA.

12. CITIZEN OF WHAT COUNTRY?

A MER.

13. FATHER'S NAME

JAMES REASER

14. MOTHER'S MAIDEN NAME

ESTA REASER

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

YES

W. W. I

16. SOCIAL
SECURITY NO.

213-07-3972

17. INFORMANT

MAYMIE REASER

ADDRESS BALTO.

407 S. BONSALE ST. 21224 MD

18. 410.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-15-1968 to 11-17-1968,
that (I) (we) last saw the deceased alive on 11-17-1968 and that in my (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

CEZAR A. LOPEZ MD

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11-18-68

23C. PHYSICIAN'S
NAME (Type)

CEZAR A. LOPEZ MD

DEGREE

23D. ADDRESS

CHURCH HOME AND HOSP. BAL. MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

11-21-68

24C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL CEM.

24D. LOCATION

(City, town, or county)

(State)

5501 FREDERICK AVE. BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.

NOV 22 1968

25B. NAME OF REGISTRAR

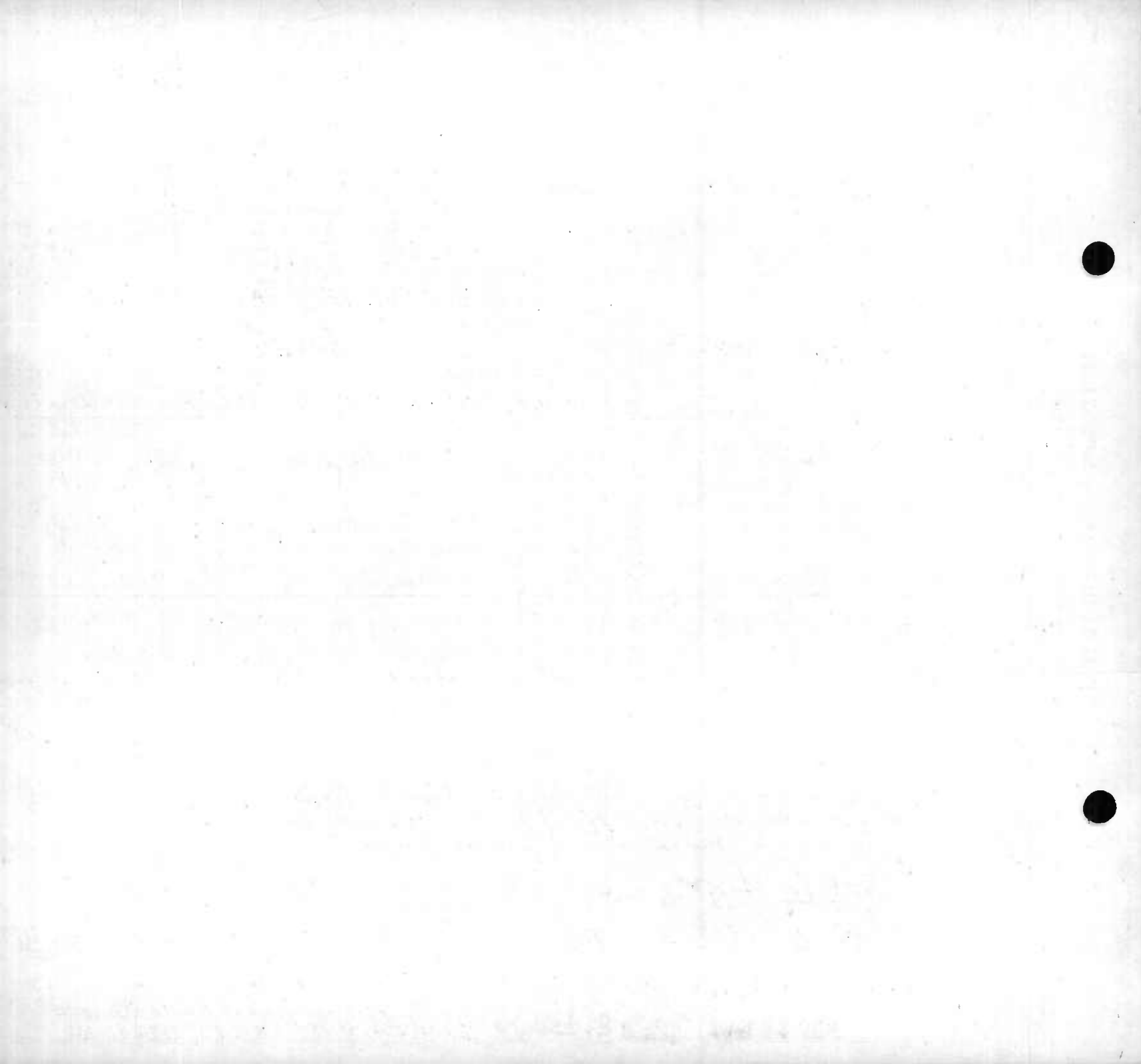
Robert E. Jenkins

25C. FUNERAL DIRECTOR

Charles S. Geiler

ADDRESS

6224 EASTERN AVE.
BALTO., 21224, MD.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11722
68-11722		CERTIFICATE OF DEATH		
BIRTH NO. 108-00323				
1. NAME OF DECEASED (Type or Print) DAVIS, KENNITHEA DARLEEN		2. DATE AND HOUR OF DEATH 11-15-68 2:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND HOSP.		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 715 N. CAREY ST. 21217		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-68	9. AGE (In years lost birthday) 11/10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME JOHN DAVIS		14. MOTHER'S MAIDEN NAME BARBARA GREEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Barbara Green 715 N. Carey St
18. 427.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARDIORESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: UNKNOWN (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. 433.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). SEVERE DEHYDRATION				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) UNKNOWN		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Nov 9 19 68 to Nov 15 19 68, that (I) last saw the deceased alive on Nov 15 19 68 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.				
23A. SIGNATURE Eric M Fine MD.				23B. DATE SIGNED 11-15-68
23C. PHYSICIAN'S NAME (Type) Eric M Fine MD.				23D. ADDRESS 2222 W. N. Ave Carrie X. Cooper - 512 N. Carrollton Ave
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-19-68		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem
24D. LOCATION (City, town, or county) (State) Baltimore Md				
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Carrie X. Cooper - 512 N. Carrollton Ave

Barbara Green

11-12-68

Nov 12 84

Nov 12 84

Unknown

NO

UNKNOWN

UNKNOWN

Cardiorespiratory Arrest

no

John Davis

CHILD

none

Barbara Green

Barbara Green

1-8-68

112 N. Green St

UNIVERSITY OF MARYLAND

112

112

112

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11723 CERTIFICATE OF DEATH

REG. NO. 68-11723

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MADA A. GERLACH		NOV. 20, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Edgewood Nursing Home				A. STATE MARYLAND	
				B. COUNTY	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 6000 Bellona Avenue	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 12, 1878	
				9. AGE (In years lost birthday) 90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Johan Gerlach		14. MOTHER'S MAIDEN NAME Mary Barber		12. CITIZEN OF WHAT COUNTRY? U?S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220 44 6817		17. INFORMANT Mr. Wm. G. Frederick 13 South St.	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Anterograde Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years	
MEDICAL CERTIFICATION					
19. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1964</u> 19 to <u>November</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>November 18</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>Loy Zimmermann M.D.</i> Loy Zimmermann M.D.				23B. DATE SIGNED 11/21/68	
23C. PHYSICIAN'S NAME (Type) Loy Zimmermann M.D.				23D. ADDRESS 3202 Harford Road Balti. Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/68		24C. NAME OF CEMETERY or CREMATORY Western Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland 21223	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213	



5-416

68-11724 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11724

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LOUISE SILVER

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 20 1968

3:15 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38

University Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 20, 1968 3:15 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

INSIDE CITY LIMITS?

Balto.

YES ☐NO ☐

6. SEX

Female

7. RACE

Colored

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

11/27/32

10. AGE (In years
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

623 S. Paca St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Isaac Taylor

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary Millen

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mary Bridges 620 S. Paca St.

19. 6440

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenio, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Septic abortion
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

651.0 11
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Unknown

Unknown

22D. TIME
OF INJURY
(APPROX.)

11 ? 68 ? m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

abortion

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Nov. 20, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/23/68

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION

(City, town, or county)

(State)

Brooklyn, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 22 1968

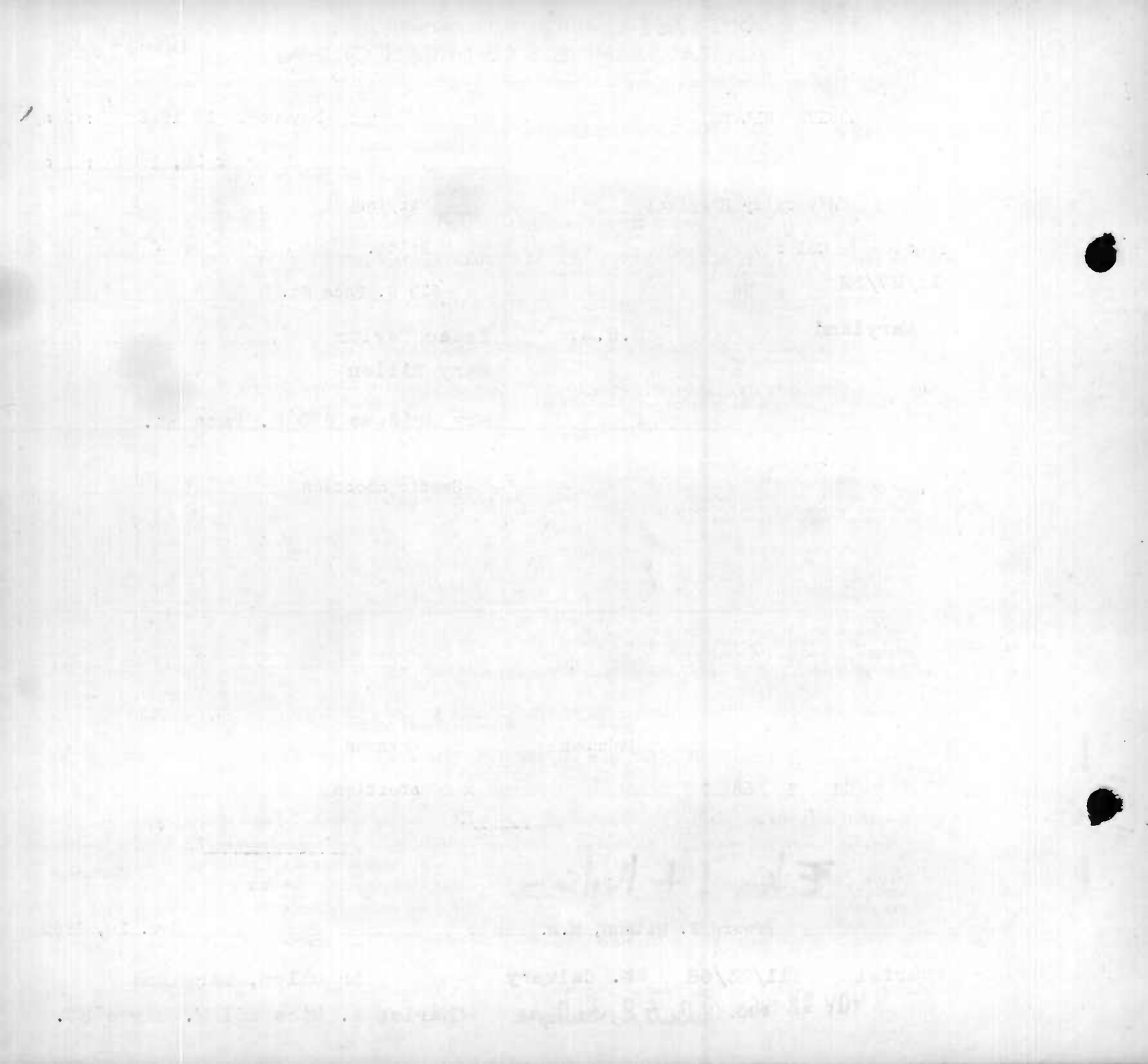
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11725 CERTIFICATE OF DEATH

REG. NO.

68-11725

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GOLDSMITH, MAHIE - 'NANNIE'		2. DATE AND HOUR OF DEATH 11.15.68 10:02 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 17-03		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND HOSPITAL			C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F 6. RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 6-4		9. AGE (In years lost birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10B. KIND OF BUSINESS OR INDUSTRY For Family		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Dorothy Honey		
ADDRESS 527 Bloom St					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.) BILATERAL PNEUMONIA UNKNOWN			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. EXPOSURE					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). EXPOSURE					
19A. DATE OF OPERATION 11.15.68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RESPIRATORY INSUFFICIENCY		20A. AUTOPSY? (Yes, or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 873 W. FRANKLIN ST.	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) NOVEMBER 13-14 1968		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FOUND UNCONSCIOUS AND HYPOTHERMIC IN UNHEATED APARTMENT	
22. I certify that (1) (this hospital) attended the deceased from 11.14.1968 to 11.15.1968 , that (1) (we) last saw the deceased alive on 11.14.1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Garvey			23B. DATE SIGNED 11.15.68		
23C. PHYSICIAN'S NAME (Type) G. GARVEY			23D. ADDRESS UNIVERSITY HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/21/68		24C. NAME OF CEMETERY or CREMATORY Not known	
24D. LOCATION (City, town, or county) (State) Baltimore		25A. DATE REC'D BY HEALTH DEPT. NOV 28 1968		25B. NAME OF REGISTRAR Robert E. Jarboya	
25C. FUNERAL DIRECTOR Marion P. King		ADDRESS 638 N. 9th St			

UNIVERSITY OF MARYLAND
HOSPITAL

23 W FRANKLIN ST

NEED 7

BILATERAL PNEUMONIA

EXFUSION

11-12-28 RESPIRATORY INSUFFICIENCY

83

11-11-28

11-11-28

RESIDENT PHYSICIAN

Garvey

UNIVERSITY HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11726		BALTIMORE CITY DEPARTMENT		REG. NO. 68-11726	
1. NAME OF DECEASED (Type or Print) LENORA ELLION			2. DATE AND HOUR OF DEATH 11/19/68 8:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital 4940 Eastern Ave. Baltimore, Maryland 21224			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1216 Lexington St.					
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-1-13	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY Part Family	11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Henry Davis			14. MOTHER'S MAIDEN NAME Lizzy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 578-24-6657		
17. INFORMANT BCH Records 4940 Eastern Ave. Baltimore, Md.			ADDRESS		
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) PULMONARY INSUFFICIENCY			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION lost. ALVEOLAR CELL Ca. LUNG			DUE TO, OR AS A CONSEQUENCE OF: 4 weeks		
(C) Pericardial Pulmonary			2 Days		
162.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 11/15/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LUNG BIOPSY		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 10-2-1968 to 11-19-1968 , that (H) (we) last saw the deceased alive on 11-19-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rolf H. Bessin			23B. DATE SIGNED 11/19/68		
23C. PHYSICIAN'S NAME (Type) Rolf H. Bessin			23D. ADDRESS Baltimore City Hospital 4940 Eastern Ave. Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 11/23/68		24C. NAME OF CEMETERY or CREMATORY Int Arbourn	
24D. LOCATION Baltimore					
25A. DATE RECEIVED NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Schuyler		25C. FUNERAL DIRECTOR M. P. Bessin 638 N. J. Union St	
ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11727 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11727

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES HARVEY HICKMAN		2. DATE AND HOUR OF DEATH 6 PM NOVEMBER 19 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY SE		5. CITY OR TOWN Baltimore INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY OF MARYLAND HOSPITAL		6. STREET AND NUMBER 2516 MADISON AVENUE		7. DATE OF BIRTH 3/5/98 9. AGE (In years last birthday) 70	
5. SEX Male	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/98		9. AGE (In years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NOT KNOWN		10B. KIND OF BUSINESS OR INDUSTRY NOT KNOWN		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HARVEY HICKMAN		14. MOTHER'S MAIDEN NAME HANNAH ST. JOHN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-07-6586		17. INFORMANT WIFE - ELLA HICKMAN - SAME AS (E)	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Hypochloremic acidosis 20% uretic - 1 1/2 months Secondary amyloidosis 90% bladder cancer 10% bladder		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Basilar Artery Thrombosis - 4 weeks (B) Myocardial Infarction - 6-8 years (C) Diabetes Mellitus - 8 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
19A. DATE OF OPERATION 3/11/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CAROTID ARTERIOGRAPHY		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (APPROX.) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None	
22. I certify that (I) (this hospital) attended the deceased from 10/23 1968 to Nov 19 1968 , that (I) (we) lost saw the deceased alive on Nov 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William B. Longue MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/20/68	
23C. PHYSICIAN'S NAME (Type) William Broughton Longue MD		23D. ADDRESS UNIVERSITY HOSPITAL BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/23/68		24C. NAME OF CEMETERY or CREMATORY Mount Airy	
24D. LOCATION (City, town, or county) Baltimore		24E. LOCATION (State) Md			
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR HAYS FUNERAL HOME 638 N. Gilman St	

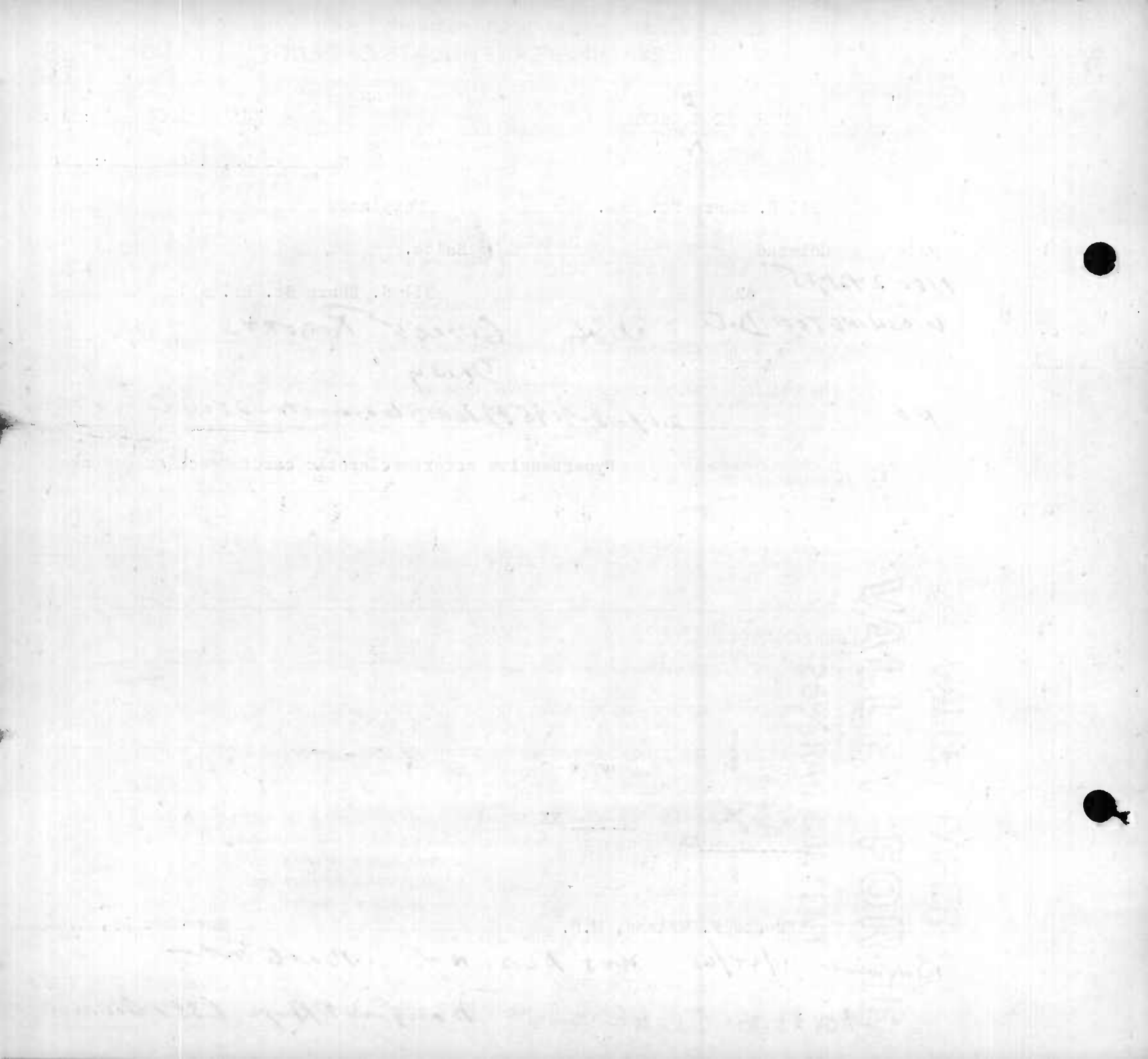
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11728

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FREDERICK GREEN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 11 Day 20 Year 1968 Hour 10:55 a.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 311 S. Sharp St. Rm. 9		3. DATE PRONOUNCED DEAD Month November Day 20 Year 1968 Hour 10:55 a.m.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH NOV 24-1905		10. AGE (In years lost birthday) 62	
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 214-18-9195	
18. INFORMANT Daisy		ADDRESS 2304 Ocean Ave	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 443x		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson		DATE SIGNED November 20, 1968	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 11/20/68	
24C. NAME OF CEMETERY or CREMATORY West Amsden		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks	
25C. FUNERAL DIRECTOR Thompson P. Hays		ADDRESS 638 N. Gilman	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11729</u>
68-11729		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JAMES THOMAS</u>		
2. DATE AND HOUR OF DEATH <u>NOV - 20 - 1968 12 30 P</u> M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>15-12</u>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3617 REISTERSTOWN Rd</u>		
C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>3617 REISTERSTOWN Rd</u>				
5. SEX <u>Male</u>	6. RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-1909</u>	9. AGE (In years lost birthday) <u>59</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Gas & Electric</u>		11. BIRTHPLACE (State or foreign country) <u>Florida S.C</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>EDWARD THOMAS</u>		
14. MOTHER'S MAIDEN NAME <u>Ann</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>216-03-9303</u>		17. INFORMANT <u>SALLIE THOMAS 3617 Reisterstown Rd</u>		
18. <u>150X I</u>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>carcinoma - esophagus</u> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____				
150X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>7/11</u> 19 <u>68</u> to <u>11/20</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/14</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Leon C. Sheer, MD</u>		23B. DATE SIGNED <u>11/21/68</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>LEON C. SHEER, MD</u>		23D. ADDRESS <u>6715 PARK HEIGHTS AVE</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11/25/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>MT AUBURN</u>	24D. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 22 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR <u>Dr. James P. Hays 638 N. GILMAN ST</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11730 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-11730

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SPARKS, CLARA M		2. DATE AND HOUR OF DEATH Nov. 21, 1968 16.00P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 27-02		
FULL NAME OF HOSPITAL OR INSTITUTION 70 GOWD'S CONVALESCARIUM			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2807 Overland Ave		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/26/1890	9. AGE (In years last birthday) 78 XX
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10B. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William C Sparks			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-07-7783		14. MOTHER'S MAIDEN NAME Florence M Fowble
17. INFORMANT Mrs Clara S Wortman			ADDRESS 1617 Walterwood Rd		
18. 413.4 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1.0 hr.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Deep femoral thrombosis left DUE TO, OR AS A CONSEQUENCE OF:		
			(C) Antecedent C.V.D.		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1968 to Nov. 21 1968, that (I) (we) lost saw the deceased alive on Nov. 21 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE J. Henry Haase M.D.				23B. DATE SIGNED Nov. 21, 1968	
23C. PHYSICIAN'S NAME (Type) J. Henry Haase M.D.				23D. ADDRESS 2926 E. Calhoun Springsham Bldg. No. 2215	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 11/25/68		24C. NAME OF CEMETERY or CREMATORY Grace Methodist	
24D. LOCATION Hampstead Maryland		24E. (City, town, or county)		24F. (State)	
25A. DATE RECEIVED BY HEALTH DEPT. Nov 22 1968		25B. NAME OF REGISTRAR John E. [unclear]		25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MANERS OFFICE
12845
CALVERT RUTH
CALVERT RUTH

BIRTH NO. 68-11731		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11731	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ruth C. Calvert		2. DATE AND HOUR OF DEATH 11/21/68 2:15 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital		A. STATE Md. B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Perry Hall D. STREET ADDRESS (If rural, give location) 329 Silver Springs Rd.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 9/15/00	9. AGE (In years lost birthday) 68	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) policewoman		10B. KIND OF BUSINESS OR INDUSTRY City of Baltimore		11. BIRTHPLACE (State or foreign country) Jamesville, Va.	
13. FATHER'S NAME William Prettyman		14. MOTHER'S MAIDEN NAME Mahalia Roberts			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 420 455-20-8883		17. INFORMANT Tom Calvert	
18. 531.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Anoxic brain damage		5d.	
		(B) DUE TO Aspiration and resp. arrest		5d.	
		(C) Peptic ulcer disease		4 yrs.	
		Chronic brain syndrome			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 540.0 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Peptic ulcer disease		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/6 19 68 to 11/21 19 68, that (I) (we) last saw the deceased alive on 11/21 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert S. Kurtz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/21/68	
23C. PHYSICIAN'S NAME (Type) Robert S. Kurtz		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 11/23/68		24C. NAME OF CEMETERY or CREMATORY Oaklawn	
				24D. LOCATION (City, town or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Leonard J Ruck Inc	
				ADDRESS Baltimore, Maryland	

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

Letter of Interest

11/12/83 2:14 PM

Mr. Baltimore - 2nd Floor
John Hopkins Hospital
350 Silver Spring Rd
P/12/00 68

F W M

William G. Gentryman
Baltimore City of Baltimore
Johns Hopkins Univ

NO ~~422-20-8883~~ Tom Catlett

Chronic brain dysfunction
Left: after disease
Aspiration of chest
Anoxic brain damage

Left: after disease NO

Robert & Kurt
Johns Hopkins Hospital
11/12/83

Robert & Kurt
Johns Hopkins Hospital
11/12/83

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11732</u>
BIRTH NO.		68-11732		
1. NAME OF DECEASED (Type or Print) <u>Trusty, Dorothy</u>		2. DATE AND HOUR OF DEATH <u>11-20-1968</u> <u>4¹⁵ P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore, Md.</u> B. COUNTY <u>1</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill Nsg. Home</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1400 John Street</u>		C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>3412 GRANTLEY ROAD</u>				
5. SEX <u>Female</u>	6. RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-2-1911</u>	9. AGE (In years last birthday) <u>56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
13. FATHER'S NAME <u>JEROME TRUSTY</u>		14. MOTHER'S MAIDEN NAME <u>VIRGIE JACKSON</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-18-4606</u>		17. INFORMANT <u>MARION BRUCE 3412 GRANTLEY Rd.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>adeno-rectal carcinoma</u>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>with bone metastases.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>urinary tract infection</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 w.</u> <u>?</u>
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>154X II</u>		21. DATE OF OPERATION <u>11-18-68</u>		
22. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>urinary tract infection</u>		23. AUTOPSY? (Yes or No) <u>No</u>		
24. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
25A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner) <input type="checkbox"/>		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
28. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		29. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		30. HOW DID INJURY OCCUR?
21. I certify that (I) (this hospital) attended the deceased from <u>11-15-68</u> to <u>11-20-68</u> , that (I) (we) lost saw the deceased alive on <u>11-18-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>E. Ellsworth Cook</u>		23B. DATE SIGNED <u>11-20-68</u>		
23C. PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook</u>		23D. ADDRESS <u>2431 Maryland Ave Balt Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-23-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk. Arbutus, Maryland</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 28 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>W.P. Bailey</u> Address <u>Kelson F. H. 1348 Calhoun St.</u>

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

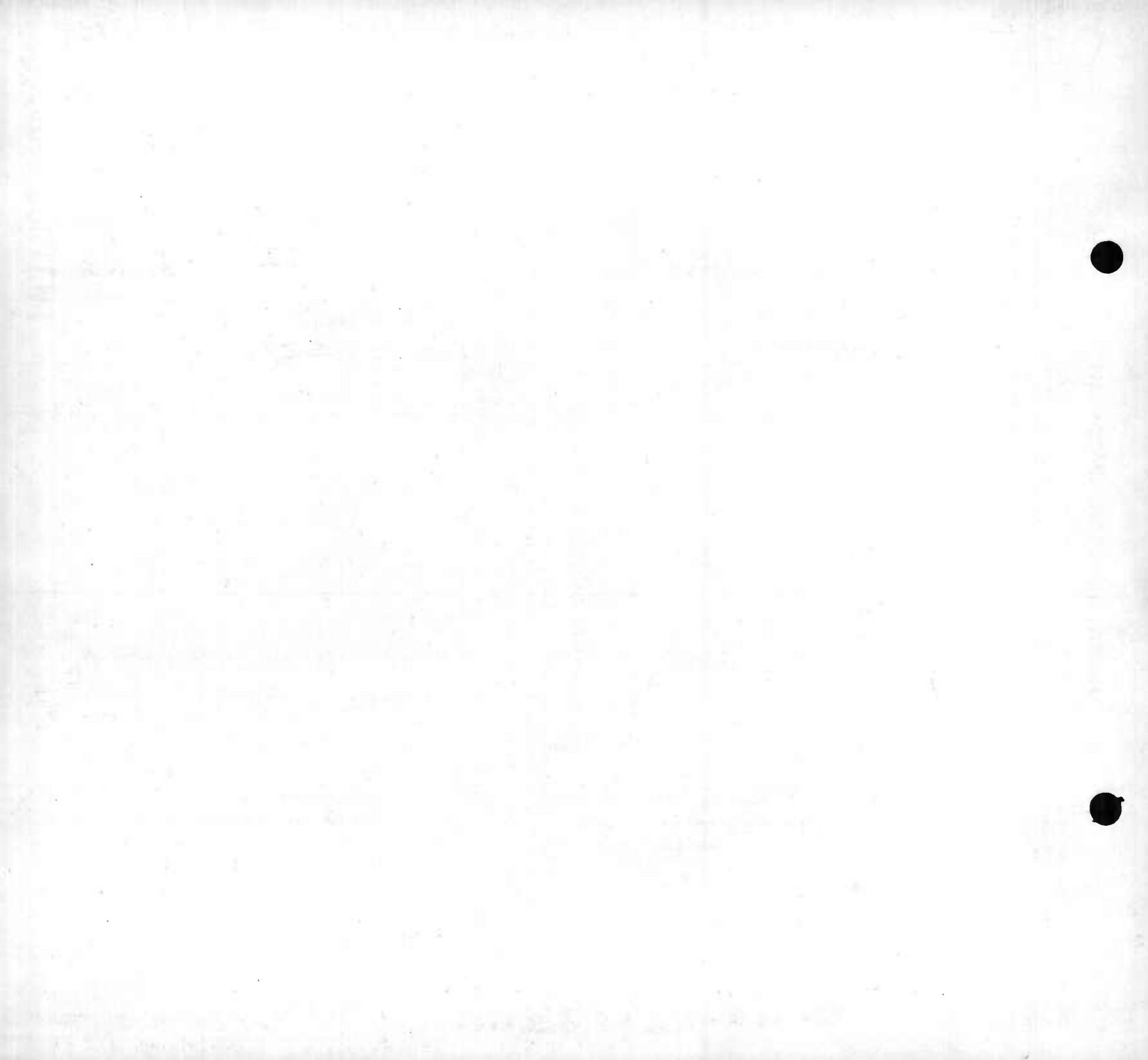
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11733			
BIRTH NO. W-425				68-11733			
1. NAME OF DECEASED (Type or Print) MYRTLE WILSON				2. DATE AND HOUR OF DEATH 11/20/68 x 6:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE, MARYLAND #21224				MARYLAND			
5. SEX FEMALE				6. RACE NEGRO			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 7-4-11			
9. AGE (In years lost birthday) 57				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Richard Harris				14. MOTHER'S MAIDEN NAME LYDIA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212-30-5221			
17. INFORMANT BCH: RECORDS				ADDRESS 4940 EASTERN AVE. BALTIMORE, MD. #21224			
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Ca of esophagus			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. DATE OF OPERATION 2 None				20. AUTOPSY? (Yes or No) YES			
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NA				22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
23. TIME OF INJURY (Month) (Day) (Year) (Hour) NA				24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) NA			
25. INJURY OCCURRED While At <input type="checkbox"/> NA Not While At Work <input type="checkbox"/>				26. WHERE DID INJURY OCCUR? NA			
27. HOW DID INJURY OCCUR? NA				28. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
29. I certify that (this hospital) attended the deceased from 8/6/68 to 11/20/68, that (we) last saw the deceased alive on 11/20/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE John Cohen M.D.				23B. DATE SIGNED 11/20/68			
23C. PHYSICIAN'S NAME (Type) JOHN COHEN M.D.				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 11-25-68			
24C. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cem.				24D. LOCATION Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968				25B. NAME OF REGISTRAR Robert E. Jankins			
25C. FUNERAL DIRECTOR Kelson F.H.				ADDRESS 1348 Calhoun St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. Such

CERTIFICATE OF DEATH

BIRTH NO. (Type or Print)		1. NAME OF DECEASED GEORGE PHILIPS		2. DATE AND HOUR OF DEATH 11-21-68 4:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 1-05	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME & HOSPITAL				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 435 S. DUNCAN 21231					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-17-06	9. AGE (In years last birthday) 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KNIFE SHARPENER		10B. KIND OF BUSINESS OR INDUSTRY ESSKAY CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CONSTANTINE FILIPOWICZ				14. MOTHER'S MAIDEN NAME FRANCES SZYDLOWSKA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-03-9286		17. INFORMANT DANIEL FILIPOWICZ ADDRESS 2111 WASHIRE AVE. BALTO. 21214	
18. 185 X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) UREMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MARKED DEHYDRATION 2 days CARCINOMA OF THE PROSTATE 2 yrs.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
177 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). P					
19A. DATE OF OPERATION 11-4-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FAIR		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-1 19 68 to 11-21 19 68 that (I) (we) last saw the deceased alive on 11-21 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dorothy A. Damm M.D. DEGREE				23B. DATE SIGNED 11-21-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS CHURCH HOME AND HOSPITAL BALTIMORE, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-23-68		24C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS Cem.	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. NOV 28 1968		25B. NAME OF REGISTRAR Robert E. Fialkowski		25C. FUNERAL DIRECTOR W. FIALKOWSKI ADDRESS 2007 EASTERN AVE. BALTO. MD. 21231	

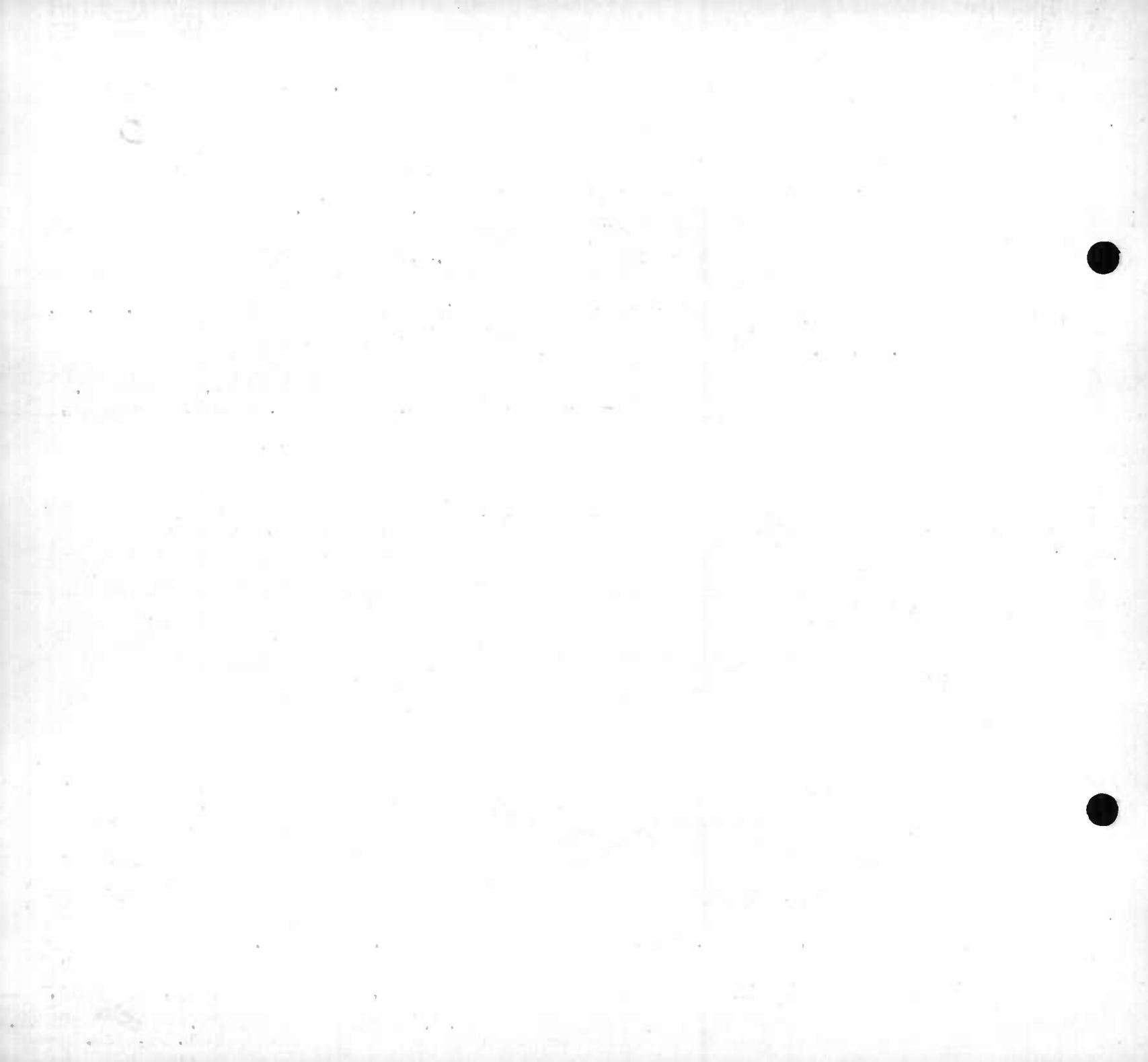


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11735 CERTIFICATE OF DEATH

REG. NO. 68-11735

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Edna Smith Helm		Nov. 17, 1968 6:12 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
90 House In the Pines -Belvedere				Maryland	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				709 E. 33rd St.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 6, 1884	84	Housewife
		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
		Own Home	Maryland		U. S. A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
J. N. O. Smith			Mary Alice Harnish		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-44-5762-J1		1317 W. Moss Ave.	
		CAUSE OF DEATH		Mrs. William R. Retzer- Peoria, Ill.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		metastatic disease			
ANTECEDENT CAUSES		Canceroma of colon			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
153.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/13 19 67 to 11/17 19 68, that (I) (we) last saw the deceased alive on 11/15 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John N. Classen M.D.				11-19-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. John N. Classen				2923 St. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/21/68		Pipe Creek Church Breth. Carroll County, Md.	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 22 1968		Robert E. Taylor		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11736 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REC. NO. 68-11736

BIRTH NO.		1. NAME OF DECEASED (Type or Print) William J. Hudson, Sr.		2. DATE AND HOUR OF DEATH 11/20/68 8:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 9400 Good Samaritan Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY (OWINGS MILLS) BALTO.		C. CITY OR TOWN OWINGS MILLS D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Good Samaritan Hospital		E. STREET AND NUMBER LINSON Rd. 53-00			
5. SEX MALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-91	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED INVESTMENT BANKER		10B. KIND OF BUSINESS OR INDUSTRY HUDSON & CO.		11. BIRTHPLACE (State or foreign country) NORWOOD, PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PATRICK ROBERT HUDSON		14. MOTHER'S MAIDEN NAME ANNA CARROLL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 248-14-1168A		17. INFORMANT WILLIAM J. HUDSON, JR.	
ADDRESS (SAME)		18. CAUSE OF DEATH 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 2-4		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-4	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 491X II		20. ASCVD; Rheumatoid Arthritis 10-15 yrs.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/19/68 19 to 11/20/68 19, that (I) (we) lost saw the deceased alive on 11/20/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Paul J. Edgar, M.D.		23B. DATE SIGNED 11/20/68		23C. PHYSICIAN'S NAME (Type) Paul J. Edgar, M.D.	
23D. ADDRESS Good Samaritan Hospital Balto., Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/23/68	
24C. NAME OF CEMETERY or CREMATORY St. Thomas		24D. LOCATION (City, town, or county) (State) Garrison Forest, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd Balto. 12, Md.	

FUNERAL DIRECTOR: IMPORTANT

Certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased as D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11737 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-11737

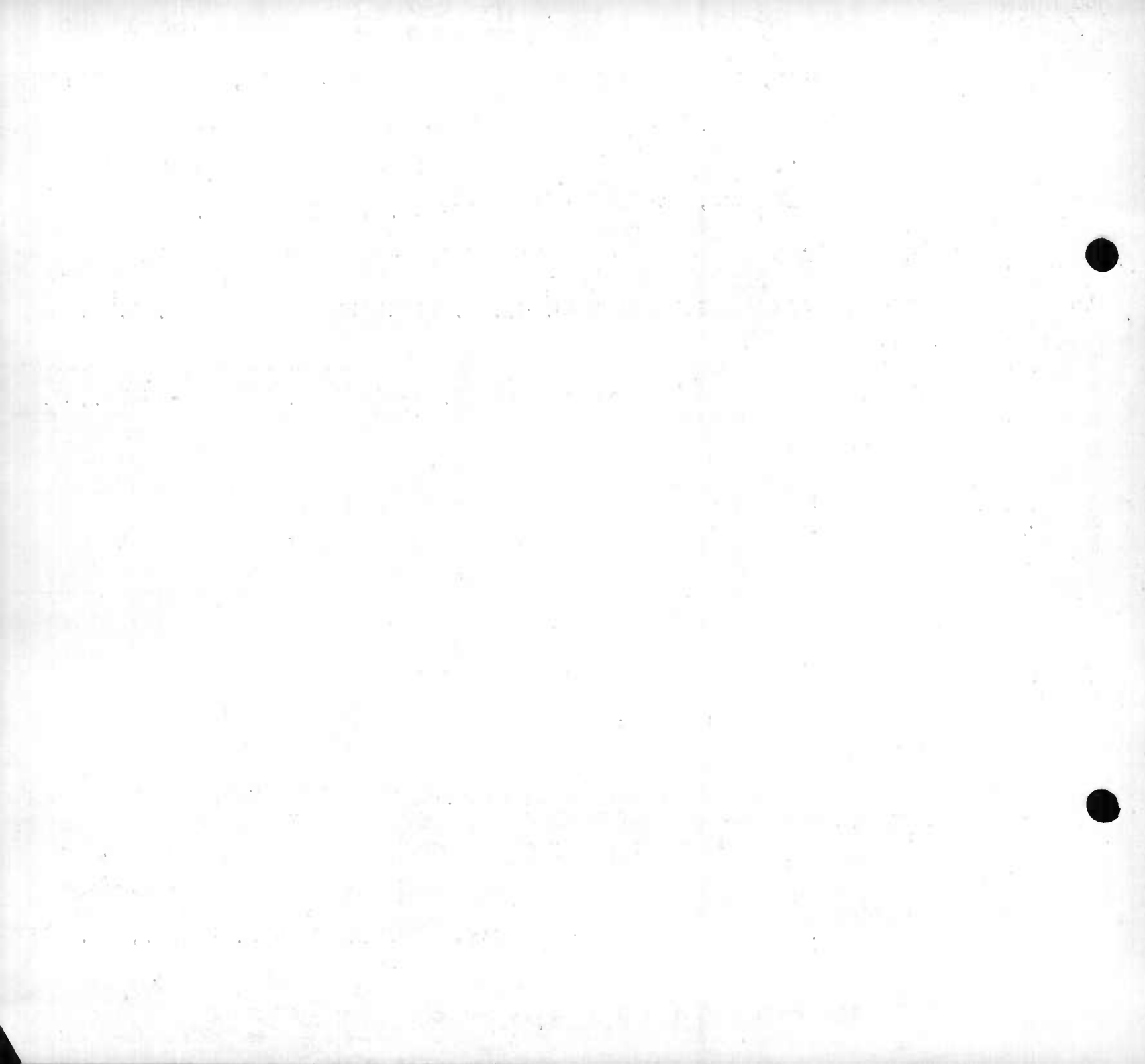
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ISABELLE R. BUCK		2. DATE AND HOUR OF DEATH November 20, 1968 10 45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 2946 Wyman Parkway		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 2946 Wyman Parkway	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/1880	9. AGE (In years lost birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed		10B. KIND OF BUSINESS OR INDUSTRY Butter & Eggs		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles H. Buck		14. MOTHER'S MAIDEN NAME Rosella Robinson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-0410		17. INFORMANT Mrs. John H. Klingstine	
18. 431.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebro-Vascular Disease Hemorrhage		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 1. Hypertension Severe 2. Arterio Sclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Gradual 11 Days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 331X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 1955 to Nov 20 1968 , that (I) (we) last saw the deceased alive on Nov 20 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. H. Woody		23B. DATE SIGNED 11-21-68		23C. PHYSICIAN'S NAME (Type) W. H. Woody	
23D. ADDRESS M.D. 1403 Park Ave., Balto., Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/23/68		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11738		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11738	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GRAY, GEORGE WASHINGTON		NOVEMBER 19, 1968 11:55PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229		MARYLAND 21229 20-07 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 155 SO. MONASTERY AVE.	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05 10 06	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESS OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY GLIDDEN CHEM. CO.		11. BIRTHPLACE (State or foreign country) W. VIRGINIA	
13. FATHER'S NAME HORACE GRAY		14. MOTHER'S MAIDEN NAME Nora		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 235 07 0982		17. INFORMANT CATON & WILKENS AVES. ADDRESS 21229 ST. AGNES HOSP. RECORDS-BALTO., MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 481X I Acute Pulmonary Edema -		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute heart Failure -			
		(B) DUE TO, OR AS A CONSEQUENCE OF: MASSIVE LOBAR PNEUMONIA -			
		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 490X II A.S.C.V.D.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 19 19 68 to NOVEMBER 19 19 68, that (X) (we) last saw the deceased alive on NOVEMBER 19 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alejandro Mejia MD				23B. DATE SIGNED 11/20/68	
23C. PHYSICIAN'S NAME (Type) ALEXANDRO MEJIA MD				23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/23/68		Mt Calvary Cem	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Special E. Jackson 1129 N. Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11739	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 12</p> <p>1. NAME OF DECEASED (Type or Print) SAMUEL BRANSON</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 11/19/68 1:05 P.M.</p> </div> </div>					
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>43 South Baltimore General Hospital</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MD B. COUNTY 22-01</p> <p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 531 SHARP ST</p>		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/19-1906	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		10B. KIND OF BUSINESS OR INDUSTRY Metal Decorating		11. BIRTHPLACE (State or foreign country) CUMBERLAND MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME DAVID BRANSON			
14. MOTHER'S MAIDEN NAME Laura B. Abe		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT WIFE ADDRESS 531 SHARP ST BALTIMORE MD			
18. 427.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE Coronary Effusion DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) Auto Rinal Failure DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF:		
434.1 II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			ASCVD		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 68 to Nov 19 19 68 , that (I) (we) last saw the deceased alive on Nov 19 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert J. Rosensteel MD				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ROBERT J. ROSENSTEEL MD				23D. ADDRESS South Balt. Gen. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 22, 1968		24C. NAME OF CEMETERY OR CREMATORY Abe Cemetery	
24D. LOCATION (City, town, or county) Near Wiley Ford, W. Va.		24E. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Taylor			

Metal Decoration

James C. Lee

Serial

Nov. 25, 1968

Age Country

Post Office No.

James E. Scarpelli, Cumberland, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11740 CERTIFICATE OF DEATH

REG. NO. 68-11740

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MR. GEORGE A. CHESTER		2. DATE AND HOUR OF DEATH 11-19-68 6:40 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 20-02			
FULL NAME OF HOSPITAL OR INSTITUTION 34 Ben Secours Hospital 2025 20. Fayette St. 21223		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 19 N. Gorman Ave					
5. SEX Male	6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/28/90	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD., Cambridge	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John W. Chester		14. MOTHER'S MAIDEN NAME Clara Bishop			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes.		16. SOCIAL SECURITY NO. 212-10-1807		17. INFORMANT Mrs. Loretta Chester	
18. ADDRESS 19 N. Gorman Ave					
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiorespiratory failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. B22 Chorea minor known pharyngeal Co.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory failure (B) DUE TO, OR AS A CONSEQUENCE OF: B22 Chorea minor (C) known pharyngeal Co.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few days one week	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 491X II					
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-18-68 to 11-19-68 , that (I) (we) last saw the deceased alive on 11-19-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. YAP M.D.		23B. DATE SIGNED 11-19-68		23C. PHYSICIAN'S NAME (Type) J. YAP M.D.	
23D. ADDRESS BONI SECOURS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-22-68		24C. NAME OF CEMETERY or CREMATORY Balti. Nat'l Cem.	
24D. LOCATION (City, town, or county) Baltimore, Md					
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1968		25B. NAME OF REGISTRAR Robert E. Fairburne		25C. FUNERAL DIRECTOR Morton A. Dyett	
1701 ADDRESS LAURENS ST					

1874

1875

1876

1877

1878

1879

1880

1881

1882

1883

1884

1885

F-425

68-11741 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11741

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BENNIE (FAULKNER) FAULKNES

2. DATE OF DEATH

Known ☐ Estimated ☐Month Day Year
November 21, 1968Hour
1:15 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL (DOA)

3. DATE PRONOUNCED DEAD

Month Day Year
November 21, 1968Hour
1:15 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX
Male7. RACE
Negro8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

11-29-1920

10. AGE (In years last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

5301 Liberty Heights Avenue

11. BIRTHPLACE (State or foreign country)

Halifax Co., Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ANDREW FAULKNER

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Westinghouse

15. MOTHER'S MAIDEN NAME

MARY GERST

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes

9/26/42 9/25/45

17. SOCIAL SECURITY NO.

18. INFORMANT

Mrs. Mable Faulkner

ADDRESS

5301 Liberty Hgts

19. 430.7
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Subarachnoid Hemorrhage

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) Rupture of Aneurysm of Circle of Willis

DUE TO, OR AS A CONSEQUENCE OF:

(C)

20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.330X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 21, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-25-68

24C. NAME OF CEMETERY or CREMATORY

Balto. Nat'l Cem.

24D. LOCATION (City, town, or county)

Baltimore,

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 22 1968

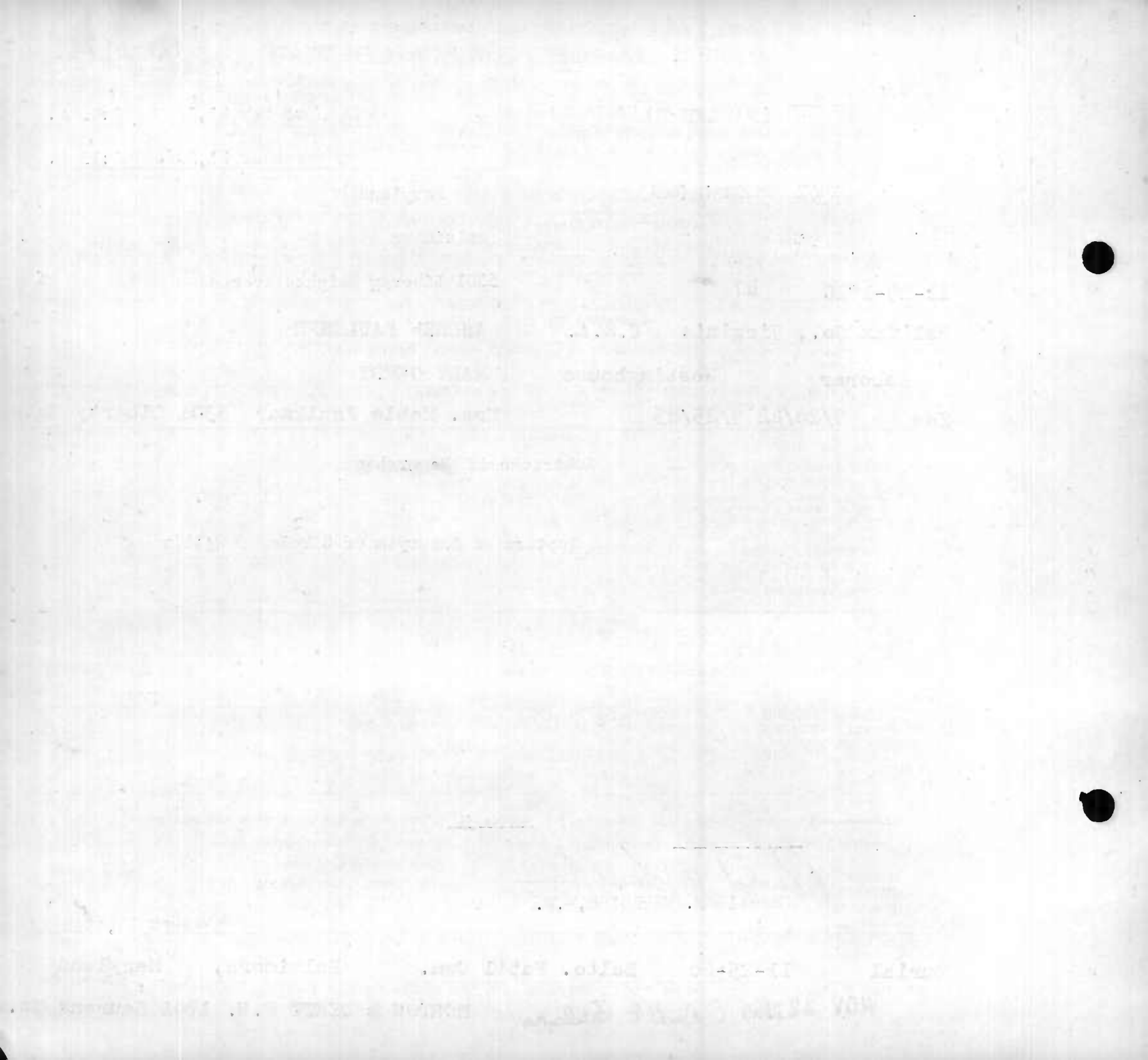
25B. NAME OF REGISTRAR

Robert E. Farkner

25C. FUNERAL DIRECTOR

MORTON & DYETT F.H. 1701 Laurens St.

ADDRESS



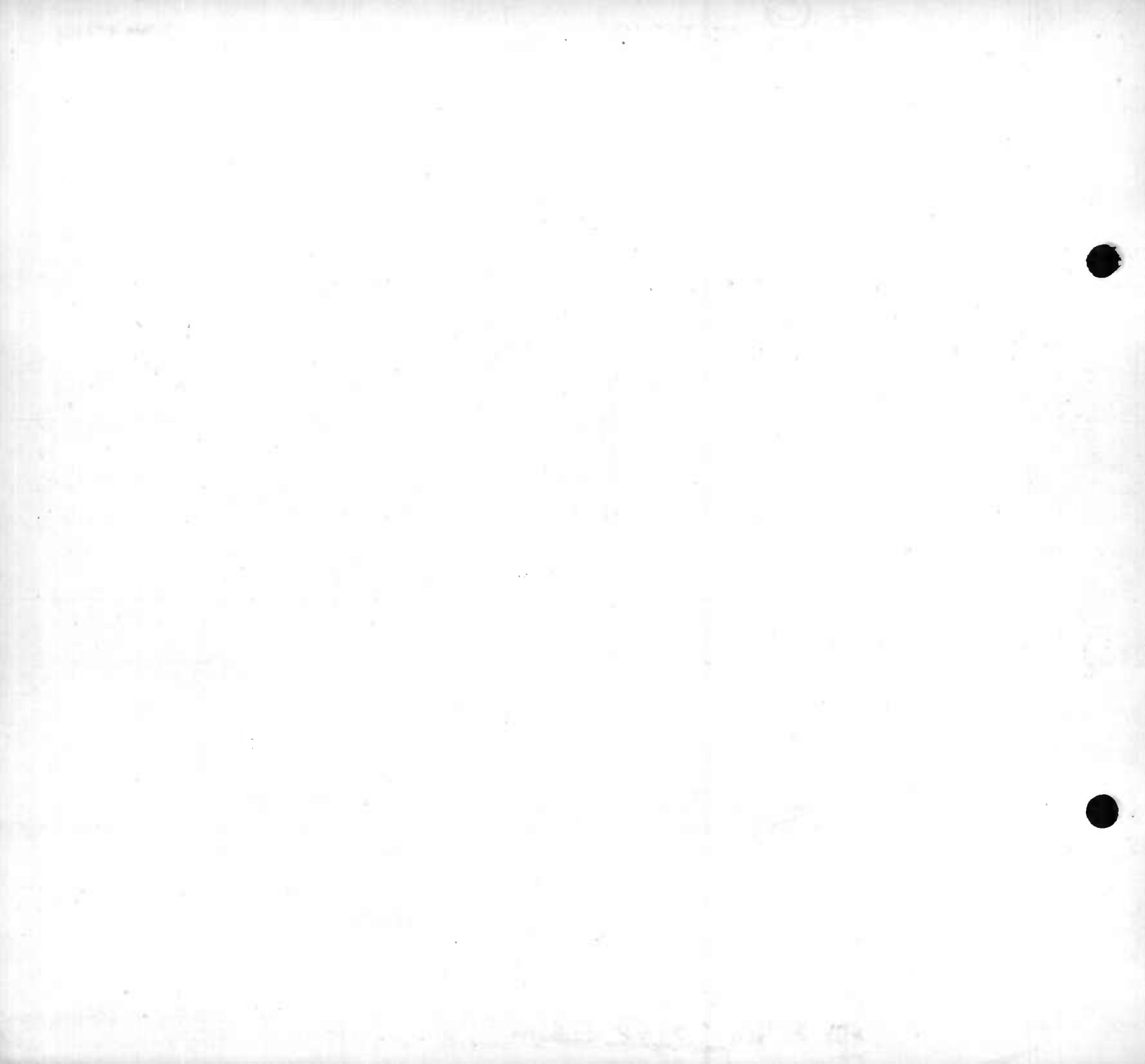
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11742-CERTIFICATE OF DEATH

REG. NO. **68-11742**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Ziegler Eleanor Henry		2. DATE AND HOUR OF DEATH 11/15/68 10 1 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Pa B. COUNTY V-35			
FULL NAME OF HOSPITAL OR INSTITUTION U.S.P.H.S.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore, Md 21211		C. CITY OR TOWN Henryville	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER none			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/12	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resort Operator		10B. KIND OF BUSINESS OR INDUSTRY Resort Operator		11. BIRTHPLACE (State or foreign country) Pa	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Henry		14. MOTHER'S MAIDEN NAME Clara Kern	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 20501 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) PULMONARY EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CEREBRAL EDEMA (B) DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYELOCYTIC LEUKEMIA (C) 1 year		CAUSE OF DEATH PULMONARY EDEMA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL EDEMA (B) DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYELOCYTIC LEUKEMIA (C) 1 year		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John C. Sutherland, M.D.		23B. DATE SIGNED Nov. 16, 1968		23C. PHYSICIAN'S NAME (Type) JOHN C. SUTHERLAND, M.D.	
23D. ADDRESS U.S.P.H.S. Room 3100 WYMAN PARK DR., BALTIMORE		24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 11-17-68	
24C. NAME OF CEMETERY or CREMATORY Stroudsburg, Pa.		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR North & Penna. Avenues Wm. J. Tickner & Sons			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11743 CERTIFICATE OF DEATH

REG. NO. 68-11743

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		STASIA E. RUPTIC		November 18, 1968 9:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 2709 N. Howard St.				Maryland	
				C. CITY OR TOWN	
				Baltimore	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 12-86	
				E. STREET AND NUMBER	
				2709 N. Howard St.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH	9. AGE (In years last birthday)
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct. 13, 1894	74 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		None		Pennsylvania	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Anastasius Kwiatkowski				Balbina Karczewski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Miss Pauline Ruptic Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteonion, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
175.0 II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11-6-1952 to 11-18-1968, that (I) (we) last saw the deceased alive on 11-13-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
E. Ellsworth Cook				2 Nov. 19, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
E. Ellsworth Cook M. D.				2431 Maryland Ave. Balto. Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		Nov. 21, 1968		Holy Redeemer Cemetery	
				Belair Road, Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 25 1968		Robert E. Janney		George J. Gonce 4001 Ritchie Hwy. Balto.	

3/10/1933

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11744 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11744

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sylvester L. Kusterer

2. DATE AND HOUR OF DEATH

11/20/68

3:35pm

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90 House in the Pines - Belvedere

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

Randallstown

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

Box 206 Deer Park Road 21133

5. SEX

Male

6. RACE

Cauc.

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

March 9, 1885

9. AGE (In years lost birthday)

83

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Clothing

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Kusterer

14. MOTHER'S MAIDEN NAME

Margaret Mary Froming

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

212 07 6233A

17. INFORMANT

Mr. Joseph L. Kusterer Box 206 Deer Park Rd.

Address Randallstown, Md. 21133

18. 433.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

Bronchopneumonia

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral thrombosis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

14 days

18 days

MEDICAL CERTIFICATION

332X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Congestive Heart Failure

19A. DATE OF OPERATION

none

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

no

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

no

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~XXXXXXX~~ attended the deceased from 9/14 19 68 to 11/20/68, that (I) ~~we~~ lost saw the deceased alive on 11/18 19 68 and that in (my) ~~our~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~we~~ ~~did not~~ view the body after death.

23A. SIGNATURE

Ronald R. Berger, M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

11/22/68

23C. PHYSICIAN'S NAME (Type)

Ronald R. Berger, M.D.

DEGREE

23D. ADDRESS

8501 Liberty Road Baltimore, Md. 21207

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

23 NOV 68

24C. NAME OF CEMETERY or CREMATORY

Lake View Cemetery

24D. LOCATION

(City, town, or county)

(State)

Carroll County, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 25 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

J. E. Lowell Lemmon

ADDRESS

4611 Park Heights Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11745 CERTIFICATE OF DEATH

REG. NO.

68-11745

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Gilbert
RUFUS POOLE

2. DATE AND HOUR OF DEATH

11-23-68 12.45 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **NEW MEXICO**
B. COUNTY **ALBUQUERQUE**

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

E. STREET AND NUMBER

ROUTE # 3 BOX 3015

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-14-02

9. AGE (In years last birthday)

65

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

ATTY. AT LAW

10B. KIND OF BUSINESS OR INDUSTRY

LAW

11. BIRTHPLACE (State or foreign country)

South Dakota

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

FLOYD POOLE

14. MOTHER'S MAIDEN NAME

MARVA

EVANS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Suzanne H. Poole, Same as 4

1890 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF

Renal papillary adenocarcinoma 18 yrs metastatic to lung + liver

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

180X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **11/13** **1968** to **11/23** **1968**, that (I) (we) lost the deceased alive on **11/22 11 PM 1968** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above **(I) (We) (did)** (did not) view the body after death.

23A. SIGNATURE

David L. Jackson

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/23/68

23C. PHYSICIAN'S NAME (Type)

DAVID L. JACKSON

23D. ADDRESS

Dept. of Med., Johns Hopkins Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

CREMATION

24B. DATE

11/25/68

24C. NAME of CEMETERY or CREMATORY

Green Mount

24D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 25 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Wm. Gook-Brooks, Inc

ADDRESS

1217 ST. PAUL ST BALTIMORE, MD

and possibly some
interest to buy a few

for

Don't T. Johnson

Sept 1902, 1000 copies

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11746	
BIRTH NO. M-520		68-11746 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Thomas Monks		2. DATE AND HOUR OF DEATH 11/23/68 1:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND	
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 49 BALTIMORE CITY HOSPITALS		C. CITY OR TOWN BALTIMORE	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
314940 EASTERN AVE. BALTIMORE 21224 MD.		E. STREET AND NUMBER 619 PARKWOOD ROAD 21222	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-10-29
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Flowers		10B. KIND OF BUSINESS OR INDUSTRY Florist	9. AGE (In years lost birthday) 39
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN EDWARD MONKS SR.		14. MOTHER'S MAIDEN NAME HELEN Cassandra Monks	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-32-1952	
17. INFORMANT BCH RECORDS:		ADDRESS 4940 EASTERN AVE. BALTIMORE MD.	
18. 20732 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Erythroblastic Leukemia	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mo	
MEDICAL CERTIFICATION			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 204.4 II			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-16-68 19 68 to 11-23 19 68 , that (I) (we) last saw the deceased alive on 11-23 19 68 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William A. Emerson M.D.		23B. DATE SIGNED 11-23-68	
23C. PHYSICIAN'S NAME (Type) WILLIAM A EMERSON M.D.		23D. ADDRESS 21224 4940 EASTERN AVE BALTIMORE CITY HOSPITALS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov. 25, 1968	24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens	24D. LOCATION (City, town, or county) (State) Bel Air, Harford Co., Maryland 21014
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968	25B. NAME OF REGISTRAR Robert E. Farber	25C. FUNERAL DIRECTOR Joseph William Foster ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print) CEPHUS H. MOSLEY				2. DATE AND HOUR OF DEATH 11-22-68 9:05 A.M.				68-11747			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL				E. STREET AND NUMBER 2024 ST. PAUL ST.							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/14/1906	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Captain				10B. KIND OF BUSINESS OR INDUSTRY Commercial Fishing Boat				11. BIRTHPLACE (State or foreign country) GEORGIA			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Edmund Mosley				14. MOTHER'S MAIDEN NAME UNKNOWN Annie L. Kirby			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-09-8760				17. INFORMANT MRS SARAH MOSLEY ADDRESS SAME AS #4 E			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio-respiratory failure				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarct, recent				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11-22-68			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: old				(C) A.S.H.D. years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) Yes			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from 11-60 to 11-22-68 , that (I) (we) last saw the deceased alive on 11-22-68 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE JOHNNY T. YAP M.D.				23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type) JOHNNY T. YAP M.D.			
23D. ADDRESS BON SECOURS HOSPITAL				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 11-26-68			
24C. NAME OF CEMETERY or CREMATORY SPRING HILL CEMETERY				24D. LOCATION (City, town, or r) EASTON,				25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968			
25B. NAME OF REGISTRAR Robert E. Fairbanks				25C. FUNERAL DIRECTOR Wm. Cook-Becker Inc.							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11748
BIRTH NO. <i>Balto Co. Md.</i> 68-11748		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LESSNER, RENEE LYNN			2. DATE AND HOUR OF DEATH 11-20-68 2:35 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF MARYLAND HOSPITAL 38			A. STATE MD. B. COUNTY BALT. CO. 53-00		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALT. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 18 NEPTUNE CT. 21234		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/3/68	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD			11. BIRTHPLACE (State or foreign country) BALT. MD.		
10B. KIND OF BUSINESS OR INDUSTRY -			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME HOWARD LESSNER			14. MOTHER'S MAIDEN NAME BRENDA VANDIERGRIFT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. -		17. INFORMANT Euom Fune Md. ADDRESS
18. 192.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CARDIORESPIRATORY ARREST			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MARASMOUS & PORTAL HYPERTENSION & ASCITES		
			(B) DUE TO, OR AS A CONSEQUENCE OF: NEUROBLASTOMA, METASTATIC		
			(C) _____		
193.9 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOV 5 1968 to 11-20 1968 , that (I) (was) last saw the deceased alive on 11-20 1968 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE Euom Fune Md. DEGREE				23B. DATE SIGNED 11-20-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-22-68		24C. NAME of CEMETERY or CREMATORY Holy Redeemed Cem.	
24D. LOCATION (City, town, or county) Balto. Md.		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Furburne		25C. FUNERAL DIRECTOR John C. Miller Inc. ADDRESS -6415 Belair Rd.	

UNIT OF DOWN AND HART

F W

GRIND
HOWARD LESSNER

no

LABORATORY RESEARCH

NEUROLOGICAL, METASTATIC
DISEASES & TUMORS

YES

11-50

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IT MEETING AT 5:30

11/18

BAIT 11/20

BRENNA VANDERKAM

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200

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	68-11749
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BRECHIN, HARRY		11/21/68		6:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md.		B. COUNTY	
UNION MEMORIAL HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3514 Cardenas Ave.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-30-10	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME ANDREW M. BRECHIN		14. MOTHER'S MAIDEN NAME ELEANOR EILMORE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 226-07-1057		17. INFORMANT Mrs. Margaret Brechin - Same	
18. 4 2 7 21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CVA. STROKE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SUBARACHNOID HEMORRAGE (B) DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 4330 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 11/19/68 to 11/21/68, that (I) (we) last saw the deceased alive on 11/21/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 11/21/68			
23C. PHYSICIAN'S NAME (Type) LUIS CINTADO MD		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-25-68		24C. NAME OF CEMETERY or CREMATORY St. Joseph's Cemetery	
24D. LOCATION Cordova, Maryland		24E. NAME OF REGISTERAR Robert E. Johnson		24F. FUNERAL DIRECTOR John C. Miller Inc-6415 Ba	
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTERAR		25C. FUNERAL DIRECTOR	

FUNERAL DIRECTOR: IMPORTANT

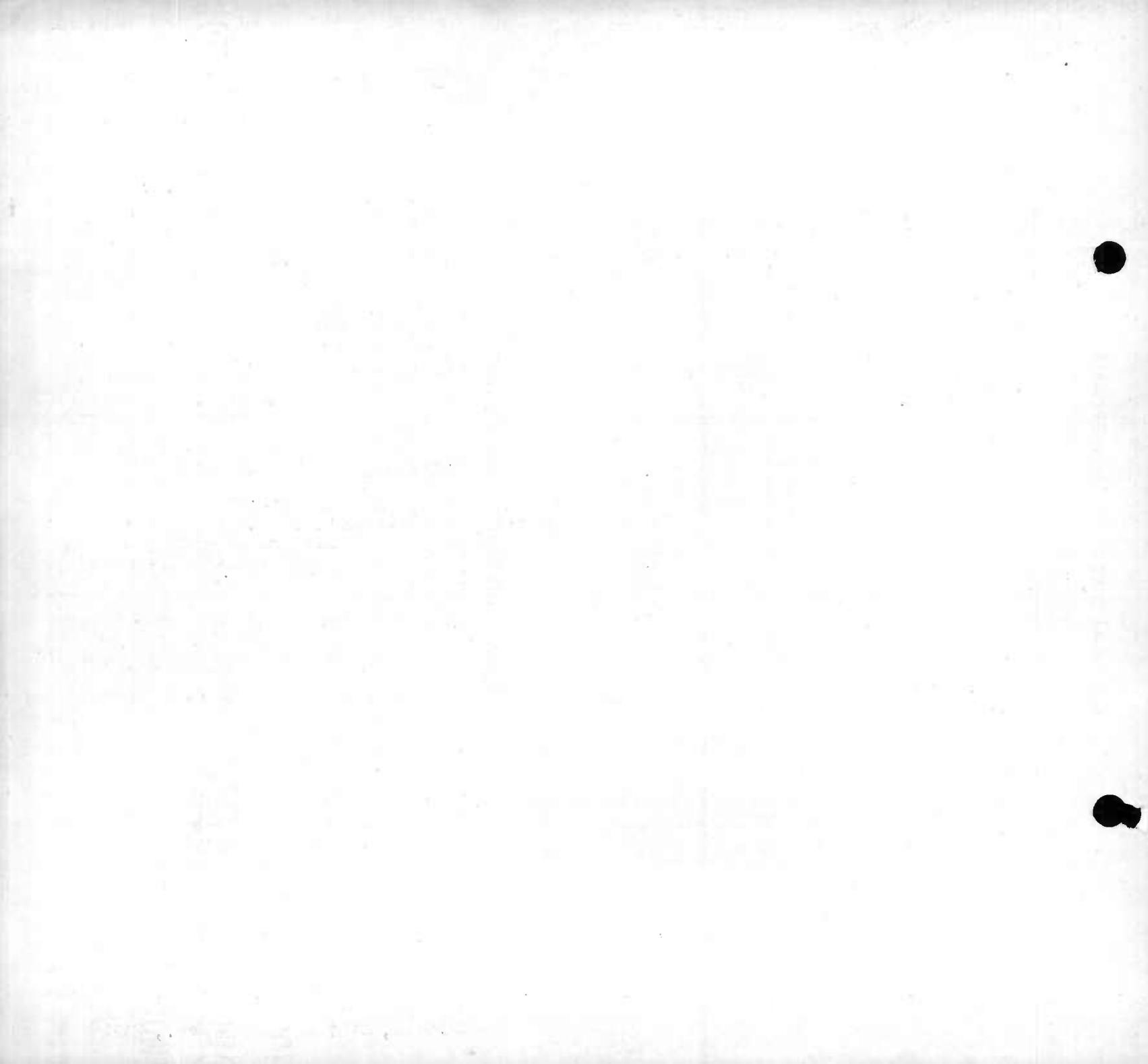
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11750</u>
1. NAME OF DECEASED (Type or Print) <u>Turner, Barbara King</u>		2. DATE AND HOUR OF DEATH <u>11/22/68</u> <u>8:30</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Montebello State Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY _____		
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY _____		8. DATE OF BIRTH <u>1/4/29</u> 9. AGE (In years last birthday) <u>77</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Thomas King</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Hay</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>214-24-5029</u>		17. INFORMANT <u>Janette Weiskopf</u> ADDRESS <u>38 Upmanor Rd.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>malnutrition</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): <u>fracture R Hip</u>		(C) DUE TO, OR AS A CONSEQUENCE OF: _____		
19A. DATE OF OPERATION <u>286.5</u> II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>4402 Sidehill Rd.</u>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>Dec 12 1967</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>fell</u>
22. I certify that (I) (this hospital) attended the deceased from <u>11/11/68</u> to <u>11/22/68</u> , that (I) (we) last saw the deceased alive on <u>11/22/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Robert W. Ireland</u>		23B. DATE SIGNED <u>11/22/68</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>Robert W. Ireland, M.D.</u>		23D. ADDRESS <u>Montebello State Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/25/68</u>		24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>NOV 25 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Witzke, 4101 Edmondson</u>		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

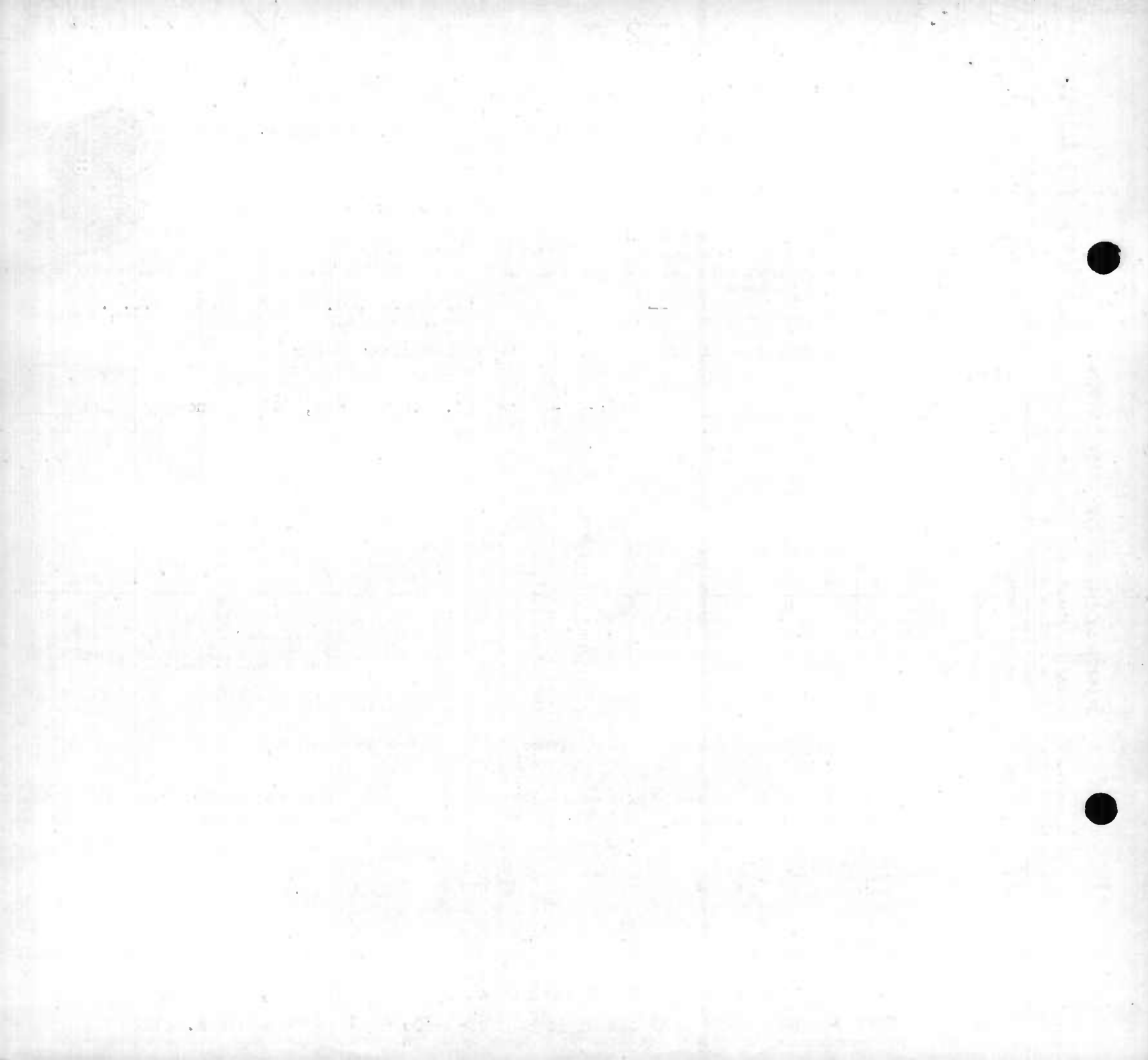
<div style="display: flex; justify-content: space-between;"> 5-560 68-11751 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 68-11751	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) Margaret Seymour	
2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 11, 27, 68 A.M. </div>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY STAFFORD ST.		C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4902 STAFFORD ST.		5. SEX F. 6. RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/29/90 9. AGE (In years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Brand		14. MOTHER'S MAIDEN NAME Mary Gilcrest	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. _____	
17. INFORMANT (Cousin) REGINA WICKLESS - Polar Ave. 21227		ADDRESS _____	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, i.e., heart failure, asphyxia, etc. It means the disease or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary arteriosclerosis, extensive. (B) DUE TO, OR AS A CONSEQUENCE OF: (Bring certificate to Med. Examiner's Office for countersigning) (C) _____	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from 11, 27, 68 to 11, 23, 1968 , that (I) (we) lost saw the deceased alive on 11, 23, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE DARABI		23B. DATE SIGNED 9:15 A - 11, 27, 68	
23C. PHYSICIAN'S NAME (Type) DARABI M.D.		23D. ADDRESS BON SECOURS Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/26/68	
24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR R. L. E. Jones	
25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229		ADDRESS _____	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

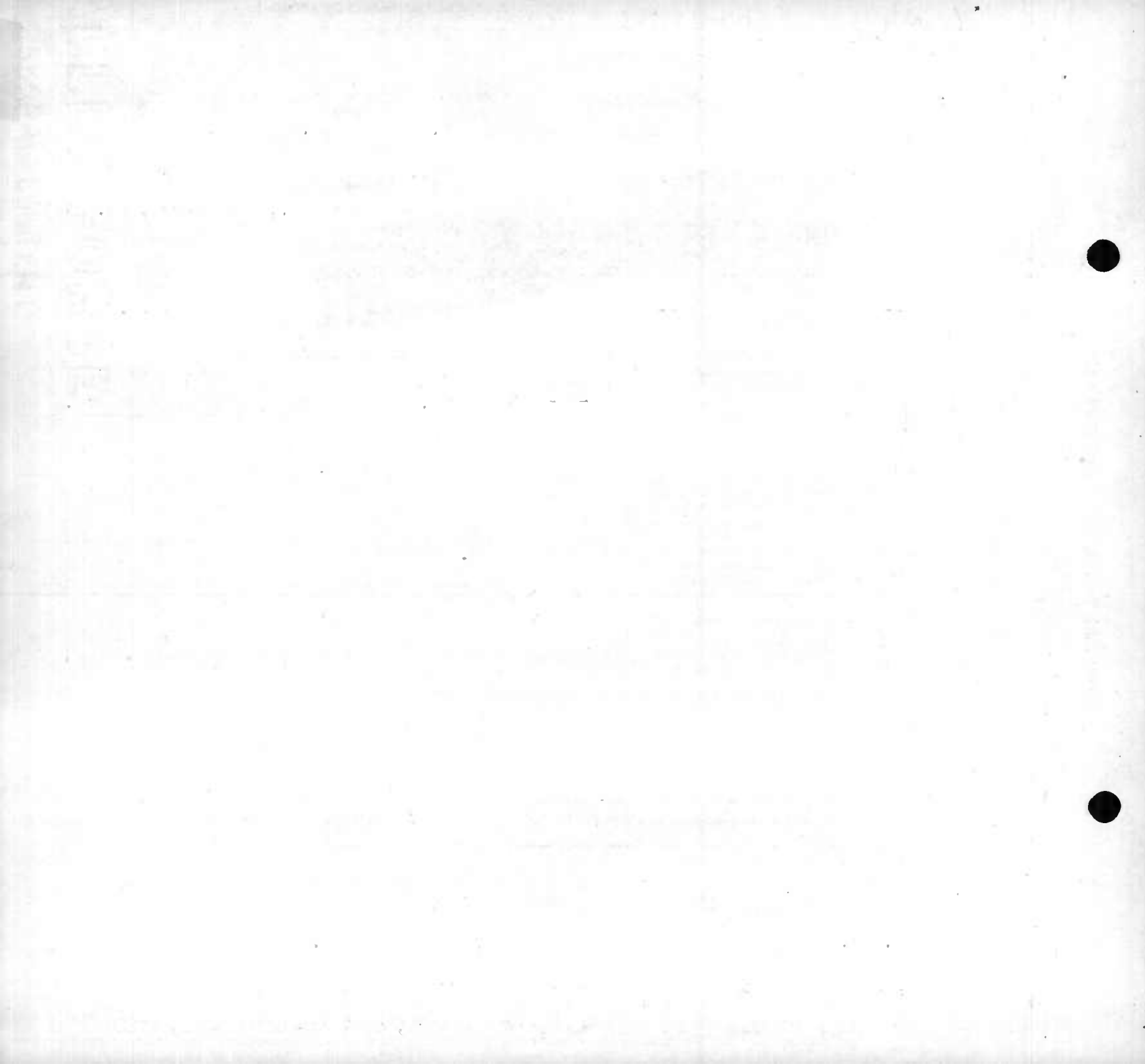
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11752
BIRTH NO. R-000		68-11752 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Rau, Anna W.		2. DATE AND HOUR OF DEATH November 22nd, 1968 10:40 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Saint Agnes Hospital 40 Caton & Wilkens Ave. 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 6117 Chanceford Road Catonsville 28		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/99	9. AGE (In years lost birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
13. FATHER'S NAME Late Charles Reinhardt		14. MOTHER'S MAIDEN NAME Charolotte Weber		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-22-7518A	17. INFORMANT Mr. J. Fred Rau, 6117 Chanceford Road	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, aslhemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiogenic shock. (B) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: 195 EVD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 124. 20-304.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from November 21 19 68 to Nov. 22 19 68 , that (I) <u>we</u> last saw the deceased alive on Nov 22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.				
23A. SIGNATURE Alejandro Mejia		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED Nov. 22- 68	
23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA		23D. ADDRESS MD St Agnes Hospital Caton & Wilkens Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/25/68	24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR P. L. & E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11753
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Augusta Lederer		2. DATE AND HOUR OF DEATH 11/21/68 11:00 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 400 Rossiter Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. 5. CITY OR TOWN Balto. 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER 400 Rossiter Ave., Baltimore, Md. 21212		
8. SEX F	9. RACE W	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. DATE OF BIRTH 3/7/1883	12. AGE (In years last birthday) 85 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		14. KIND OF BUSINESS OR INDUSTRY ---		
15. FATHER'S NAME August Heinzerling		16. MOTHER'S MAIDEN NAME Maria Junger		
17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ---		18. SOCIAL SECURITY NO. 219-10-2267		
19. INFORMANT Mrs. Thelma German, 400 Rossiter Ave.		20. ADDRESS		
21. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anteroseclerosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
22. DATE OF OPERATION 450.0		23. CONDITION FOR WHICH OPERATION WAS PERFORMED		
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
26. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		27. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
28. I certify that (I) (this hospital) attended the deceased from Sept 1st 1963 to Nov 21 1968		29. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
30. SIGNATURE Dr. Wm. Helfrich		31. DATE SIGNED 11-23-68		
32. PHYSICIAN'S NAME (Type) Dr. Wm. Helfrich		33. ADDRESS 5006 Roland Ave.		
34. BURIAL CREMATION, REMOVAL (Specify) Burial		35. DATE 11/25/68		
36. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		37. LOCATION (City, town, or county) (State) Baltimore, Maryland		
38. DATE REC'D BY HEALTH DEPT. NOV 25 1968		39. NAME OF REGISTRAR Robert E. Jankura		
40. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229		41. ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11754	
68-11754		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
MCHARGUE, FRANCES		11-21-68 8:35 A M.			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
A. STATE MARYLAND B. COUNTY Baltimore 53-00					
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER PARADISE AVE. Nursing Home					
6. SEX F	7. RACE W	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 6-25-93	10. AGE (In years lost birthday) 75	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. A01-28-4952		17. INFORMANT ADDRESS ST AGNES RECORDS ; WILKENS & CATON AV	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE ? cardiac arrest ?			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) atrial fibrillation			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
(C) A.S.V.D.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 433.1 II	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 11-19-1968 to M 8:35 11-21-68, that (X) (we) lost saw the deceased alive on 11-21-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (dX) (X) view the body after death.					
23A. SIGNATURE Robert Widmeyer MD		23B. DATE SIGNED 11 21 68		23C. PHYSICIAN'S NAME (Type) ROBERT WIDMEYER, MD	
23D. ADDRESS BALTO MD 21229 ST AGNES HOSPITAL WILKENS & CATON					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/22/68	24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229	



FUNERAL DIRECTOR: IMPORTANT

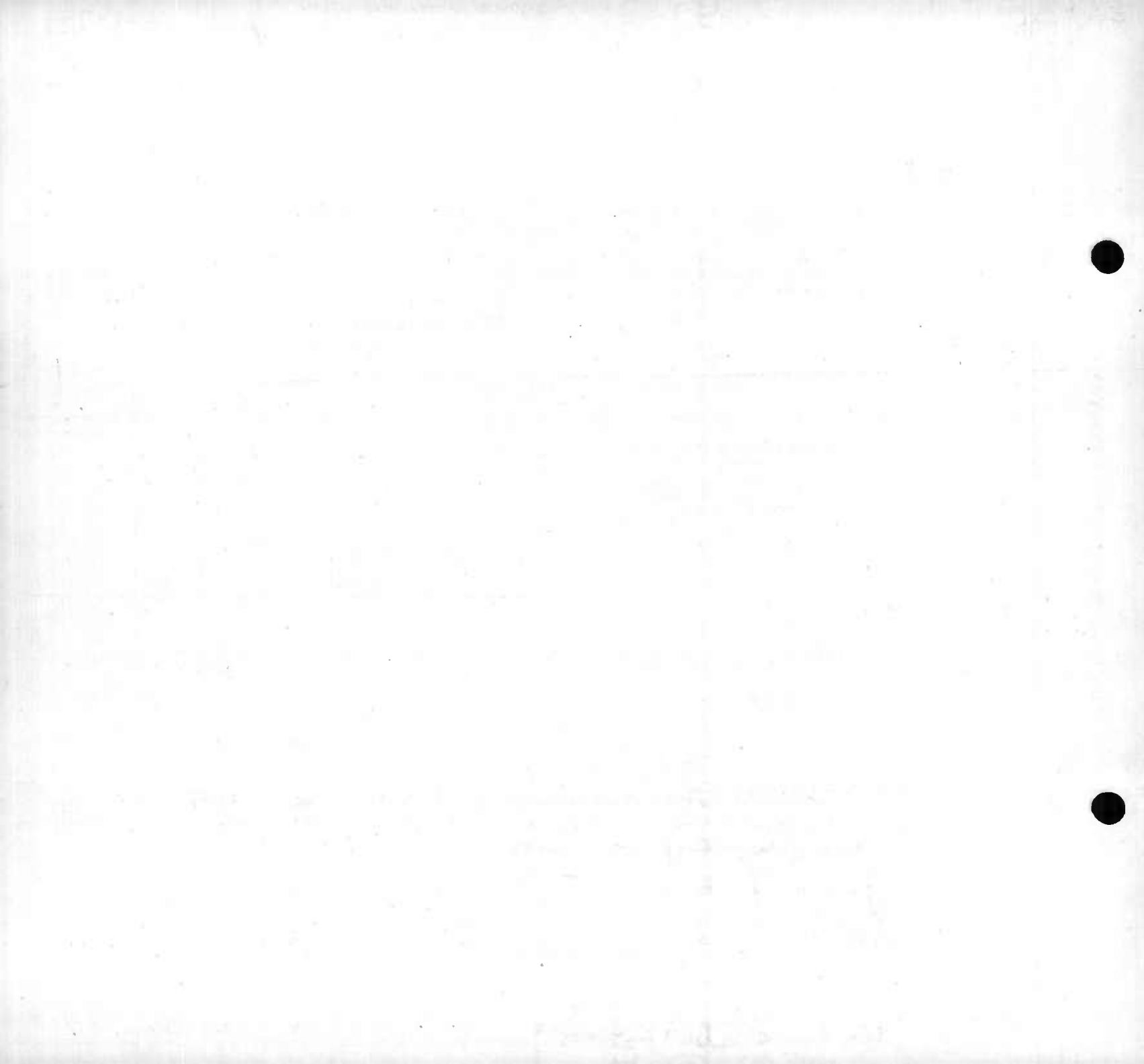
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11755 CERTIFICATE OF DEATH

REG. NO. X

68-11755

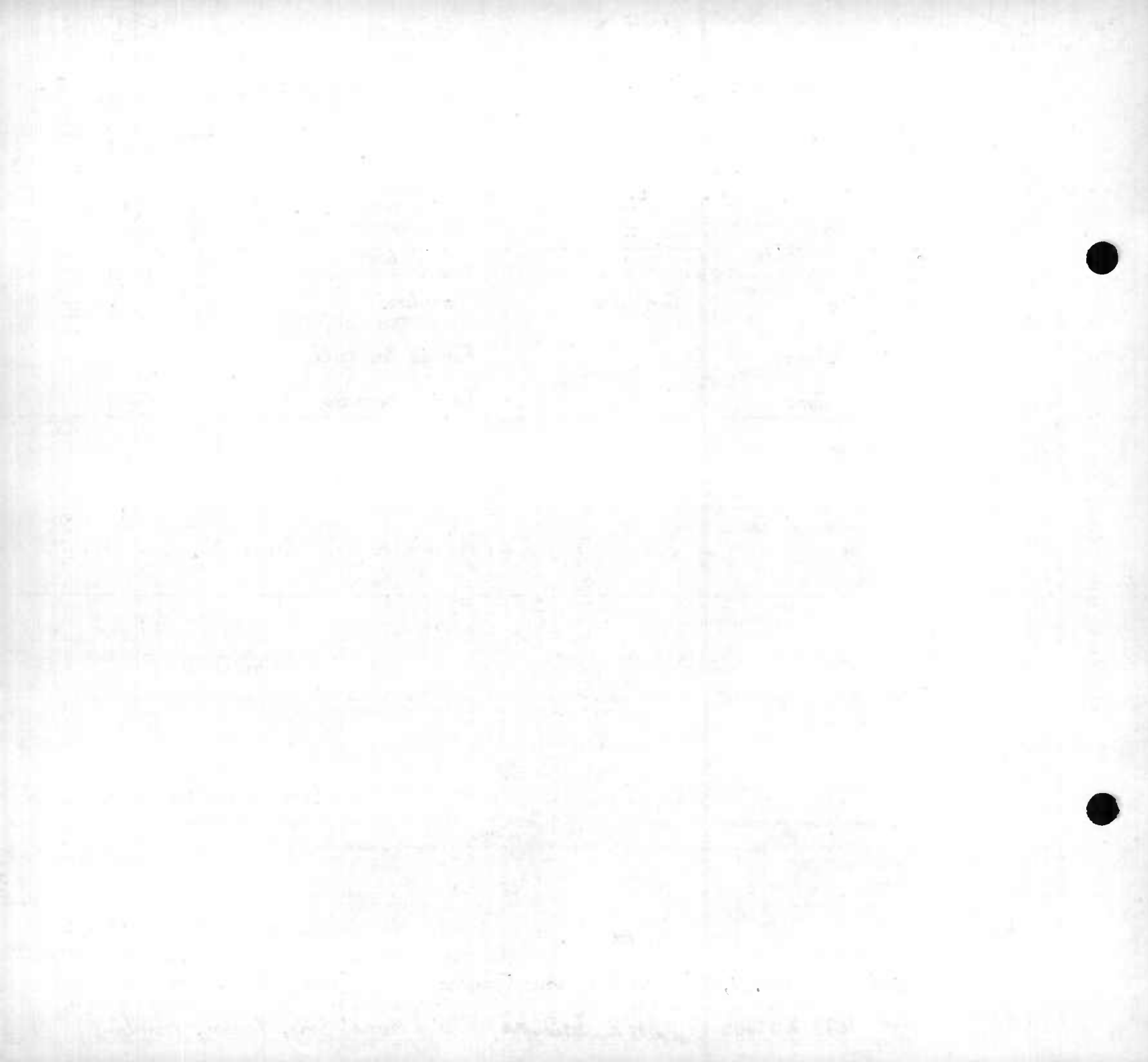
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GEORGE C. MEDAIRDY, M.D.		2. DATE AND HOUR OF DEATH 11-21-68 12:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY OF MARYLAND HOSPITAL			A. STATE MD. B. COUNTY Baltimore C. CITY OR TOWN REISTERSTOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 230 MAIN STREET		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-98	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME John Medairy			14. MOTHER'S MAIDEN NAME CARRIE ROCK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-38-0140		17. INFORMANT Mrs. Mary E. Medairy Reisterstown, Md.	
18. 193 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) THYROID CARCINOMA & METASTASES ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. 194 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 19 November 19 68 to 21 November 19 68 , that (H) (we) last saw the deceased alive on 21 November 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE John M. Jackson M.D. DEGREE				23B. DATE SIGNED 21 November 1968	
23C. PHYSICIAN'S NAME (Type) JEAN M. JACKSON, M.D. DEGREE				23D. ADDRESS University of Maryland Hospital 3200 E. Baltimore, Md. 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/23/68		24C. NAME OF CEMETERY or CREMATORY All Saints	
24D. LOCATION Reisterstown, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR J. T. Eline & Sons Reisterstown, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11756	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Ambrose, Edith Elizabeth</u>				November 18th, 1968 2 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co</u> <u>53-00</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 Saint Agnes Hospital</u> <u>Caton & Wilkensa Aves.</u> <u>21229</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>147 Sanford Ave. 21228 Catonsville</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/11/1899</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Patrick Callary</u>	
14. MOTHER'S MAIDEN NAME <u>Fannie May Bull</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Family Records</u>	
18. <u>410.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Atherosclerosis and 7 weeks old</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Inf.</u> (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hrs.</u> <u>Years and Weeks.</u>					
19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u> <u>Hypertension</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/30/68</u> to <u>11/14/68</u> , that (I) (we) lost saw the deceased alive on <u>11/17/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>SONMEZ</u> <u>Adnan SONMEZ MD.</u>				23D. ADDRESS <u>1011 Frederick Rd., Md. 21228</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Nov. 21, 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Poplar Grove Cemetery</u>	
24D. LOCATION <u>Cockeysville, Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>NOV 25 1968</u>			
24F. NAME OF REGISTRAR <u>Robert E. Taylor</u>		24G. FUNERAL DIRECTOR <u>John Brown's Sons, Towson, Maryland</u>			



L-265

68-11757 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11757

BIRTH NO.

1. NAME OF DECEASED KATHERINE A. LOUGHRANKATHERINE LOUGHRAN2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ 11 17 68 9:30 p.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 914 E. Preston St.3. DATE PRONOUNCED DEAD Month Day Year Hour
November 17, 1968 9:30 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS

Balto.YES ☒ NO ☐

6. SEX

Female

7. RACE

WhiteB. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

Feb. 23, 1885 83

10. AGE (In years last birthday)

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

914 E. Preston St.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Patrick J. Loughran

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

at Home15. MOTHER'S MAIDEN NAME
Box 65 Rt. 10 PASADENEAnnie T. Gilcrest LAKE SHORE, MD.

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. M.L. Denner19. 412.21 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Hypertensive arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE Edward F. Wilson M.D.CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.November 18, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/21/68

24C. NAME of CEMETERY or CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 25 1968Robert E. JohnsonH.W. Mears & Son 805 N. Calvert St.

W. F. H. H.

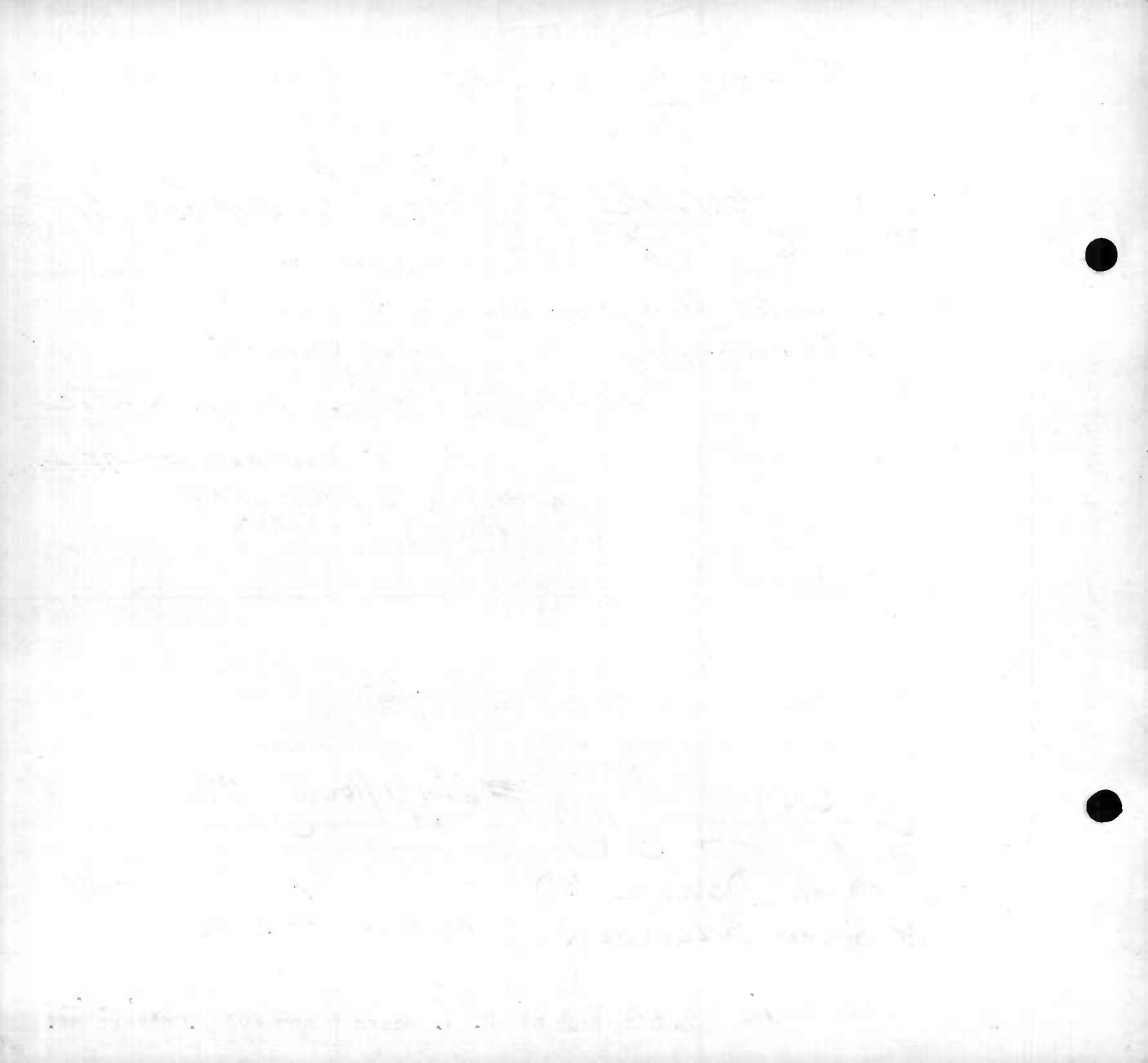
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11758 CERTIFICATE OF DEATH

REG. NO. 68-11758

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>RICHARD MONTGOMERY</u>		2. DATE AND HOUR OF DEATH <u>7²⁵ 11/16/68</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>MD</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u>			C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>1726 N. CHARLES ST</u>		
5. SEX <u>Male</u>	6. RACE <u>@</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 8, 1903</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Mercy Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>R. E. Montgomery</u>			14. MOTHER'S MAIDEN NAME <u>Cora Russell</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give word or dates of service)		16. SOCIAL SECURITY NO. <u>239-14-2475</u>		17. INFORMANT <u>Thos. Gayton Social Worker, Mercy Hospital</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE MYOCARDIAL INFARCTION & CARDIOGENIC SHOCK</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>75 min.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: <u>year</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6 PM 11/16 1968</u> to <u>7 PM 11/16 1968</u> , that (I) (we) lost saw the deceased alive on <u>11/16 1968</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. Susan Bollinger MD</u>				23B. DATE SIGNED <u>11/17/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. Susan Bollinger</u>		23D. ADDRESS <u>MERCY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/22/68</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE RECEIVED <u>NOV 25 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H. W. Mears & Son 805 N. Calvert St.</u>	



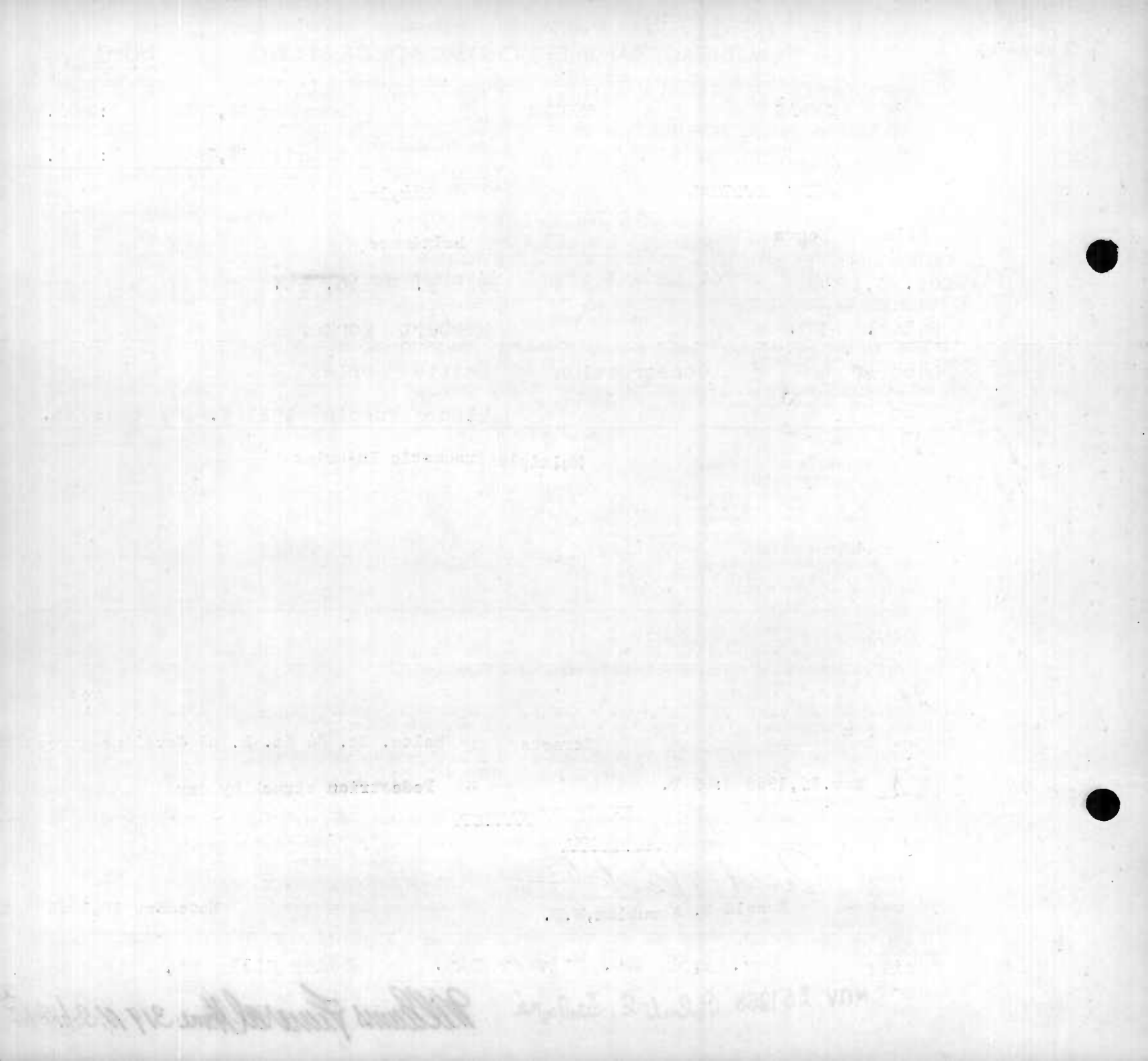
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11759

BIRTH NO.

1. NAME OF DECEASED (Type or Print) THOMAS YORKER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 19, 1968 Hour 7:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 HOPKINS HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 19, 1968 7:00 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		D. INSIDE CITY LIMITS? 6-05 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH Oct. 3, 1924		10. AGE (In years lost birthday) 44 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 1518 E. Balto. St.
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME Herbert Yorker
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Construction	15. MOTHER'S MAIDEN NAME Nettie Harris
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS Elnora Turpin 1521 W. Saratoga St.
19. E-814.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E-812.4 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Multiple Traumatic Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Streets	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Nov. 15, 1968 8:05 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Balto. St. 84 ft. E. of Caroline Street		22F. HOW DID INJURY OCCUR? Pedestrian struck by car	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) yes	
ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 19, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov. 23, 1968	24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	24D. LOCATION (City, town, or county) (State) Ceder Hill Md.
25A. DATE RECEIVED BY HEALTH DEPT. NOV 25 1968	25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	25C. FUNERAL DIRECTOR ADDRESS Williams Funeral Home 319 N. Schroeder St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11760
68-11760				CERTIFICATE OF DEATH
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) CLARK ANNA		2. DATE AND HOUR OF DEATH 11.21.68 950 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOUSE IN THE PINES, BELVEDERE 2525 W. BELVEDERE AVE		C. CITY OR TOWN BALTIMORE	D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2525 W. BELVEDERE AVE				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/76	9. AGE (In years last birthday) 92
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10B. KIND OF BUSINESS OR INDUSTRY Gilpen Drug Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Benjamin Clark		14. MOTHER'S MAIDEN NAME Amelia Wentz		
15. Was Deceased Ever in U. S.-Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-10-9253		17. INFORMANT Mrs. John Herold
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ACUTE PULMONARY EDEMA (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH ACUTE PULMONARY EDEMA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: DISEASE (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HRS 20 YRS
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II		NONE		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from 10.15 19 62 to 11.21 19 68 , that (I) (we) lost saw the deceased alive on 11.21 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Paul G. Herold, M.D.		23B. DATE SIGNED 11/21/68		23C. PHYSICIAN'S NAME (Type) PAUL G. HEROLD, M.D.
23D. ADDRESS 10 W. MADISON ST BALTIMORE MD				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/23/68	24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd-12

DEPARTMENT STORE

SALE PERSON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11761 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11761

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>JAMES J. CURRY</i>		2. DATE AND HOUR OF DEATH <i>11/20/68</i> <i>2 35</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 MERCY HOSPITAL</i>			C. CITY OR TOWN <i>BALTO.</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>515 CAMPBELL LANE</i>		
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/29/04</i>	9. AGE (In years lost birthday) <i>64</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CUSTODIAN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bryn Mawr College</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>LEONARD CURRY</i>			
14. MOTHER'S MAIDEN NAME <i>FLORENCE BROWN</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>220-18-7742</i>		17. INFORMANT ADDRESS <i>James J. Curry, Jr. 5601 Ready Ave.</i>			
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>RESPIRATORY ARREST</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>6 hr.</i>			(B) <i>BRAIN STEM HEMORRHAGE</i> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <i>ASCUS</i> DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>422.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/19 68</i> to <i>11/20 68</i> , that (I) (we) last saw the deceased alive on <i>11/20 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. Susan Bollinger MD</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>M. SUSAN BOLLINGER</i>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-22-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 25 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fairbanks</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212</i>			

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

AMENDED BY COURT ORDER 68-11762				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11762	
BIRTH NO. Film G-513 10-5-11 mm Item #7				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		WILLIAM A. MESSENGER		2. DATE AND HOUR OF DEATH		11-20-68 11:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
NORTH CHARLES GEN. HOSPITAL				1360 BALTIMORE		27-09	
C. CITY OR TOWN		BALTIMORE		D. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				1360 PENTWOOD RD MD 21212			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	10-03-07	61			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED - ADLEY EXPRESS				DELAWARE		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ROBERT MESSENGER				Anna White MESSENGER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		220-10-8000		ROSL. CHART			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				VENTRICULAR FIBRILLATION MINUTES			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CORONARY ARTERY DISEASE YEARS			
				(C) CHRONIC OBSTRUCTIVE LUNG DISEASE YEARS			
420.1 II				PNEUMONIA - Lung Abscess WEEK			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 4/13 1968 to 11/20 1968, that (I) (we) last saw the deceased alive on 11/13 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
MARIANO A. TOLENTINO				4/20/68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
MARIANO A. TOLENTINO		NORTH CHARLES GEN HOSP.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		Nov. 23, 1968		Hill Crest Cemetery		Federalsburg Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
NOV 25 1968		Robert E. Johnson		Tramptson Funeral Home Federalsburg Maryland			

WAGNER - Camp 27

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11763 CERTIFICATE OF DEATH

REG. NO. 68-11763

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES BAYNE		2. DATE AND HOUR OF DEATH 11-21-68 4:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital 33			C. CITY OR TOWN 1915 E. LANVALE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER BALTIMORE 1915 E. LANVALE ST.		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-25-24	9. AGE (In years last birthday) 44
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA.	
13. FATHER'S NAME JESSE BAYNES			14. MOTHER'S MAIDEN NAME DELILAH WATSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 210-14-7915		17. INFORMANT BERTHA BAYNE 1915 E. LANVALE ST	
18. 188X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Cardiac failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia (B) DUE TO, OR AS A CONSEQUENCE OF: CA of bladder (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. 181.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 5		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 5		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 5		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 5	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date _____ and hour _____ from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry A. Wise				23B. DATE SIGNED 21 Nov 68	
23C. PHYSICIAN'S NAME (Type) HENRY A. WISE 11 M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-27-68		24C. NAME OF CEMETERY or CREMATORY MT ALBURN	
24D. LOCATION BALTIMORE Md.		24E. (City, town, or county) (State)			
25A. DATE RECEIVED BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR JOSEPH KNIGHT 1639 N. BROADWAY	

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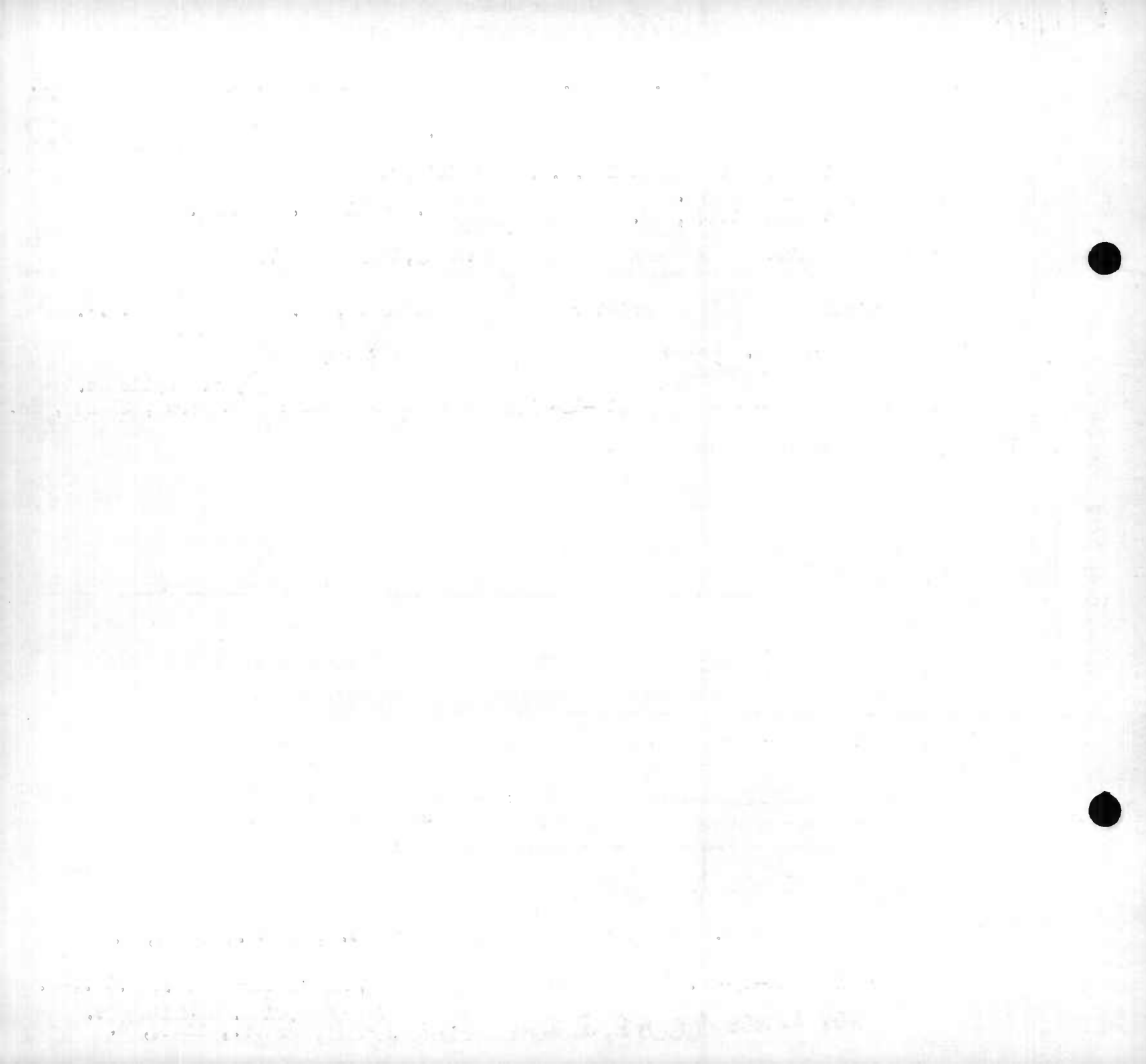
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11764 CERTIFICATE OF DEATH

REG. NO. 68-11764

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GUSTAVUS A. KOLBE.		November 22, 1968 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
Baltimore City Hospital D.O.A. 4940 Eastern Ave. Baltimore 21224, Md.				Md.	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Male White				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				E. STREET AND NUMBER	
Retired				305 S. Baylis St. # 21224.	
10B. KIND OF BUSINESS OR INDUSTRY				9. AGE (In years last birthday)	
Painter				June 25, 1889 79	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Baltimore, Md.				U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
John H. Kolbe				Georgianna Jubb	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
No				12-12-6342	
17. INFORMANT				ADDRESS	
Rose Ellen Kolbe				305 S. Baylis St. Baltimore, 21224, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
427.0 I					
CAUSE OF DEATH					
Coronary Heart Failure - Cachexia					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
434.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from Jan. 1960 to 11/22 1968, that (I) (we) lost saw the deceased alive on 11/15 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
JOSEPH R. LIBERTO MD.				11/23/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOSEPH R. LIBERTO				3508 Bank St., Balto., 21224, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11-25-68.		Oak Lawn Cemetery	
24D. LOCATION		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
7225 Eastern Blvd., Ba. Co., Md.		NOV 25 1968		Robert E. Jenkins	
24G. ADDRESS		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR	
901 S. Conkling St. Balto., 21224, Md.		Robert E. Jenkins		Charles J. Seiler	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
68-11765		68-11765		X
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Rose L. SIMS		11-22-68 12:15 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
Church Home Hosp 100 N Broadway BALT MD 21231		A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Essex</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER		
Church Home Hosp 100 N Broadway BALT MD 21231		7 HELENA AVE		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-7-20	48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
House Wife		Housewife		MARYLAND
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
LEONARD LONG		Virginia Stokes		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
No --		213 16 6374		CLYDE SIMS (HUSB)
18. <u>430.9</u> I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Subarachn. Hemorrh.		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		cerebrovax. accident		
		(C) H P N		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
0				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
330X II				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from <u>11-9-68</u> to <u>11-22-68</u> that (I) <u>we</u> last saw the deceased alive on <u>11-22-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
J. M. M. D. 11-22-68		11-22-68		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Jose F. M. D. S. M. D.		Church Home Hosp 100 N. Broadway BALT MD 21231		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial		11/25/68		Oak Lawn Cemetery
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
NOV 25 1968		Robert E. T. J. J.		Bruzdzinski Funeral Home 1407 Eastern Ave.
24D. LOCATION (City, town, or county)		24E. ADDRESS		
Baltimore Co., Md.		Baltimore Co., Md.		

M-635

68-11766 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11766

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) RAYMOND MARTIN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> November 21, 1968 12:45 a.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour November 21, 1968 12:45 A.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Reisterstown D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX Male	7. RACE White	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Nov. 7, 1930		10. AGE (In years last birthday) 38 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Dept.		14B. KIND OF BUSINESS OR INDUSTRY Head Ski Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean		17. SOCIAL SECURITY NO. 230-28-4169	
18. INFORMANT Alma E. Martin		19. ADDRESS 319 Leyton Rd., Reisterstown, Md.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E812.0 I		CAUSE OF DEATH Multiple Traumatic Injuries complicated by (A) IMMEDIATE CAUSE Hemoperitoneum and Infarction of Liver (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Nov. 18, 1968 9:05 P.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Walnut Ave. W. of Park Hgts Avenue		22F. HOW DID INJURY OCCUR? Driver in auto-auto collision	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 21, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 23, 1968	
24C. NAME OF CEMETERY or CREMATORY Evergreen Memorial Gardens		24D. LOCATION (City, town, or county) (State) Finksburg, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR H. J. Schacht		ADDRESS Owings Mills, Md.	

53-06-95

djs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11767	
BIRTH NO. L-516		68-11767	
1. NAME OF DECEASED (Type or Print) Evelyn M Lambert		2. DATE AND HOUR OF DEATH 20 Nov 68 6:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND B. COUNTY BALTIMORE Co	
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN MIDDLE RIVER D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-29-12 9. AGE (In years lost birthday) 56	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK		14. MOTHER'S MAIDEN NAME KATIE BAUSCH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) VMK		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS 21224	
BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular accident	
18B. ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
18C. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 19 Nov 19 68 to 20 Nov 19 68, that (1) (we) last saw the deceased alive on 20 Nov 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE David J. Riley MD		23B. DATE SIGNED 20 Nov 68	
23C. PHYSICIAN'S NAME (Type) DAVID J. RILEY M.D.		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO. MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/23/68	
24C. NAME OF CEMETERY or CREMATORY CAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Jankura	
25C. FUNERAL DIRECTOR J. G. CONNELLY SONS		ADDRESS 300 MALE	



BALTIMORE CITY HEALTH DEPARTMENT 68-11768 CERTIFICATE OF DEATH

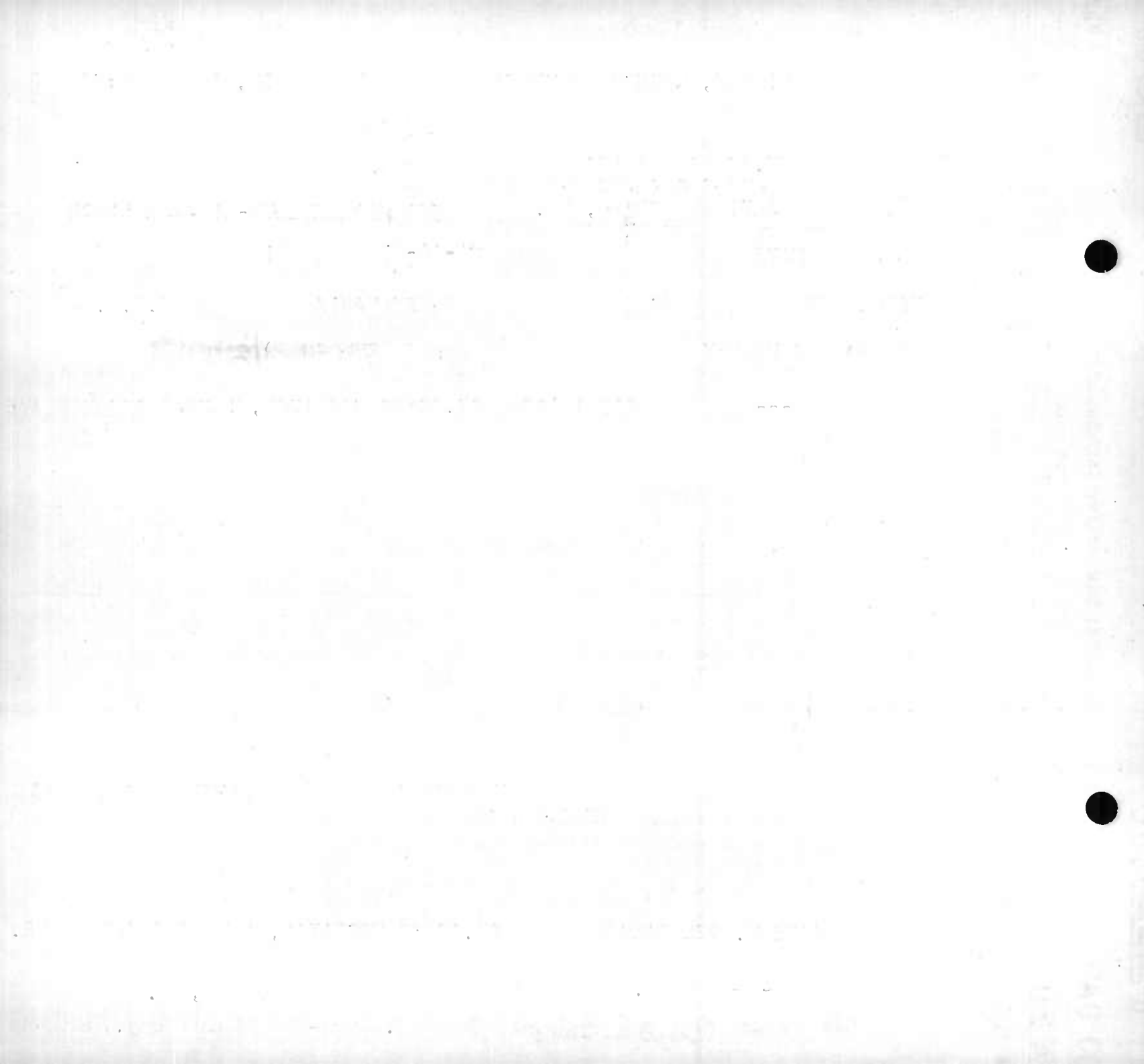
REG. NO. 68-11768

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BIRELY, KATHRYNE THERESA		NOVEMBER 18, 1968 5:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND	
ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 21229, MD.				C. CITY OR TOWN PASADENA	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 8551 MAIN AVENUE-RIVIERA BEACH	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	04-14-87	81	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		NONE		PENNSYLVANIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN MC KELVEY			MARY ANDERSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO ---		2170154208		ST. AGNES HOSPITAL, WILKENS & CATON AVE	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
410.9 I					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
420.1 II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 18 1968 to NOVEMBER 18 1968, that (I) (we) last saw the deceased alive on NOVEMBER 18 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Jame V. Del Pilar				11/18/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JAME V. DEL PILAR				ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11-21-1968		St. Catherine's Cemetery	
				Quarryville, Pa.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 25 1968		Robert E. Jenkins		George J. Gonce-4001 Ritchie Hgwy., Baltimore	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released by medical examiner



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11769	
BIRTH NO. S-520		68-11769		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Schunck, Albert C.			2. DATE AND HOUR OF DEATH November 21, 1968, 5:30 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital #21224			A. STATE MARYLAND		
B. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 4940 EASTERN AVE. BALTIMORE, MD.			F. STREET AND NUMBER 3920 EAST FRATT ST. BALTIMORE MD. 21224		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-1917	9. AGE (In years last birthday) 71 yrs	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY BALTO. TRANSIT CO.		11. BIRTHPLACE (State or foreign country) MARYLAND, BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME HARRY SCHUNCK		
14. MOTHER'S MAIDEN NAME MAY OBITZ			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 218-09-8336A			17. INFORMANT BCH: RECORDS ADDRESS 4940 EASTERN AVE. BALTIMORE, MD. 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 436.91			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE Sepsis		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Cerebro-vascular accident, 2		
			(B) Urinary tract		
			DUE TO, OR AS A CONSEQUENCE OF:		
			(C) Post prostatectomy on 10/18/68		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 331X II			Wound disruption		
19A. DATE OF OPERATION 10/18/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostatic Hypertrophy		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10/8 1968 to 11/21 1968, that (2) (we) last saw the deceased alive on Nov 21 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE H Semajdian		23B. DATE SIGNED Nov 21 1968 6:40 p.m.	
23C. PHYSICIAN'S NAME (Type) H. SEMAJDIAN		23D. ADDRESS Assistant Resident in Urology Johns Hopkins Hosp - 601 North Broadway			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-25-68		24C. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.	
24D. LOCATION 7401 GERMAN HILL RD., MD.		25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Charles S. Ziller		25D. ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68-11770 CERTIFICATE OF DEATH

REG. NO. 68-11770

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Willard P Parker</i>		2. DATE AND HOUR OF DEATH <i>11-23-68</i> <i>1:40 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>-</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i> <i>43</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1520 Riverside Ave</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-12-99</i>		9. AGE (In years last birthday) <i>69</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>?</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>?</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>US</i>			13. FATHER'S NAME <i>Joseph Parker</i>		
14. MOTHER'S MAIDEN NAME <i>Marjory E. Parks</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes. WW II</i>		
16. SOCIAL SECURITY NO. <i>213-10-1533</i>			17. INFORMANT <i>Admission sheet</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>491X I</i> CAUSE OF DEATH <i>Emphysema</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Bronchitis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>502.0 II</i> <i>Myocardial Infarction - old</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-18</i> 19 <i>68</i> to <i>11-23</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-23</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>C. G. Baumann MD</i> DEGREE				23B. DATE SIGNED <i>11-23-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>C. G. BAUMANN MD</i>				23D. ADDRESS <i>South Baltimore General Hospital</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>11/27/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Bethesda</i>	
24D. LOCATION (City, town, or county)		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 25 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>W. J. Taylor - 130 E. Tolson Ave.</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11771	
BIRTH NO.		68-11771		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ARLENE Thelma White		2. DATE AND HOUR OF DEATH Nov 16 1968 8:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD University Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Spring Grove State Hospital			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/3/12	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME DANIEL BUCKLER		14. MOTHER'S MAIDEN NAME BIRDIE BUCKLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-14-2628		17. INFORMANT Charles Samorodin M.D. University Hospital	
18. 450X-161.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 465X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Respiratory Failure & anuria DUE TO, OR AS A CONSEQUENCE OF: 2° to pulmonary embolus (B) massive & Ca larynx DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 28 hrs	
19A. DATE OF OPERATION 0 Nov		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/12/68 19 68 to 11/16/68 19 68 , that (I) (we) last saw the deceased alive on 11/16 8:30 AM 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles Samorodin M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/16/68	
23C. PHYSICIAN'S NAME (Type) Charles S. Samorodin M.D.		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 11-20-68	24C. NAME OF CEMETERY or CREMATORY TRINITY MEM. GARDENS		24D. LOCATION (City, town, or county) (State) WALDORF, CHARLES, MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD.	

(1)

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

CHICAGO, ILL.

1913

RECEIVED

THE UNIVERSITY OF CHICAGO
PHYSICS DEPARTMENT
CHICAGO, ILL.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11772
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GEORGE J. Maisel		2. DATE AND HOUR OF DEATH Novem 20 / 1968 1:55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 4 UNION MEMORIAL Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. CO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 513 VALCOUR ROAD 21228		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/1892	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHRISTIAN MAISEL			14. MOTHER'S MAIDEN NAME ELEANORA DILL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW. I, 1918-1919		16. SOCIAL SECURITY NO. 215-05-2336A		17. INFORMANT ANNA MAISEL ADDRESS 513 Valcour Rd BALTO MD 21208	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Gente myocardial infarction (A) IMMEDIATE CAUSE cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: ASCVD + CHF (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1:55pm.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/16/1968 19 to Novemb 20 19 68 , that (I) (we) lost saw the deceased olive on Novemb. 20 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Enrique Ellenbogen MD				23B. DATE SIGNED Nov/20/1968	
23C. PHYSICIAN'S NAME (Type) ENRIQUE ELLENBOGEN MD		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/25/68		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL Cem	
24D. LOCATION BALTO.		24E. (City, town, or county) (State) MD			
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ES [Signature] ADDRESS 301 Frederick Rd Baltimore MD	

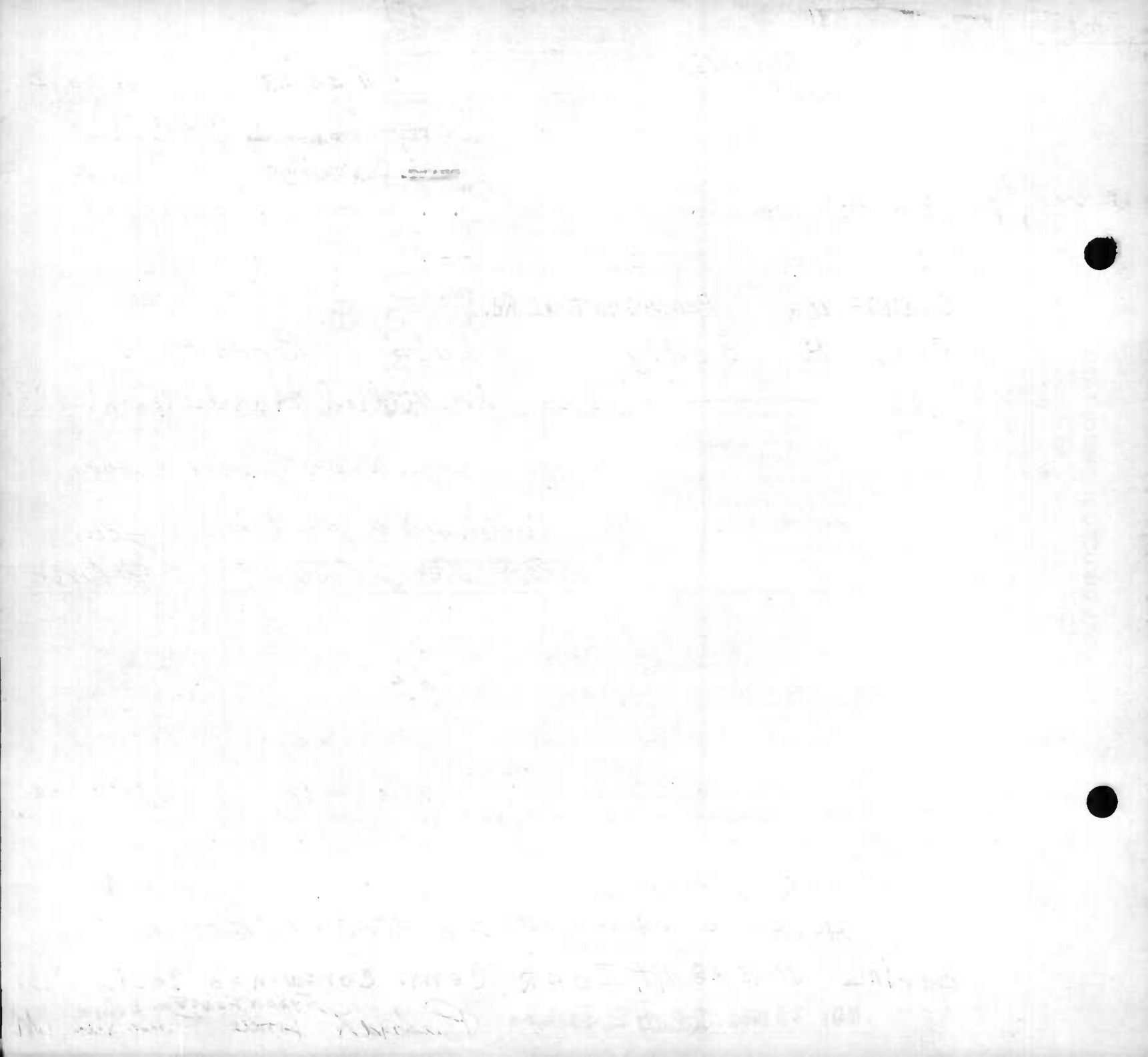
Handwritten text, possibly a signature or name, appearing as "Handwritten text" (mirrored).

Handwritten mark, possibly a stylized letter or symbol, appearing as "Handwritten mark" (mirrored).

Handwritten mark, possibly a stylized letter or symbol, appearing as "Handwritten mark" (mirrored).

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11773
BIRTH NO. 68-11773		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Sheridan Phillip Boddy</i>		2. DATE AND HOUR OF DEATH <i>11-20-68 7:30 A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Bolton Hill Nursing & Convalescent Center</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Cecil Co.</i> C. CITY OR TOWN <i>Conowingo</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>R. D. #1, Conowingo, Maryland 57-00</i>		
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-8-1910</i>	9. AGE (In years last birthday) <i>58</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Penn. Central Rd.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John H. Boddy</i>		
14. MOTHER'S MAIDEN NAME <i>Lula Bradford</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>217-07-7995</i>		17. INFORMANT ADDRESS <i>Mrs. Mildred Harris Peachbottom</i>		
18. <i>412.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>420.0 II</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>coronary heart disease</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>arteriosclerosis heart disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>left ventricular failure</i> <i>April 1968</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>9/16</i> 19 <i>68</i> to <i>11/20</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/20</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Al Martin</i>		23B. DATE SIGNED <i>11/20/68</i>		23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MAHNT MD</i>
23D. ADDRESS <i>2 E. READ ST BAL MD 21202</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		
24B. DATE <i>11-23-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MT. ZION Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Conowingo Cecil Md.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 25 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Richard L. Goodie</i> ADDRESS <i>167m e Resing St, Md.</i>



FUNERAL DIRECTOR: IMPORTANT

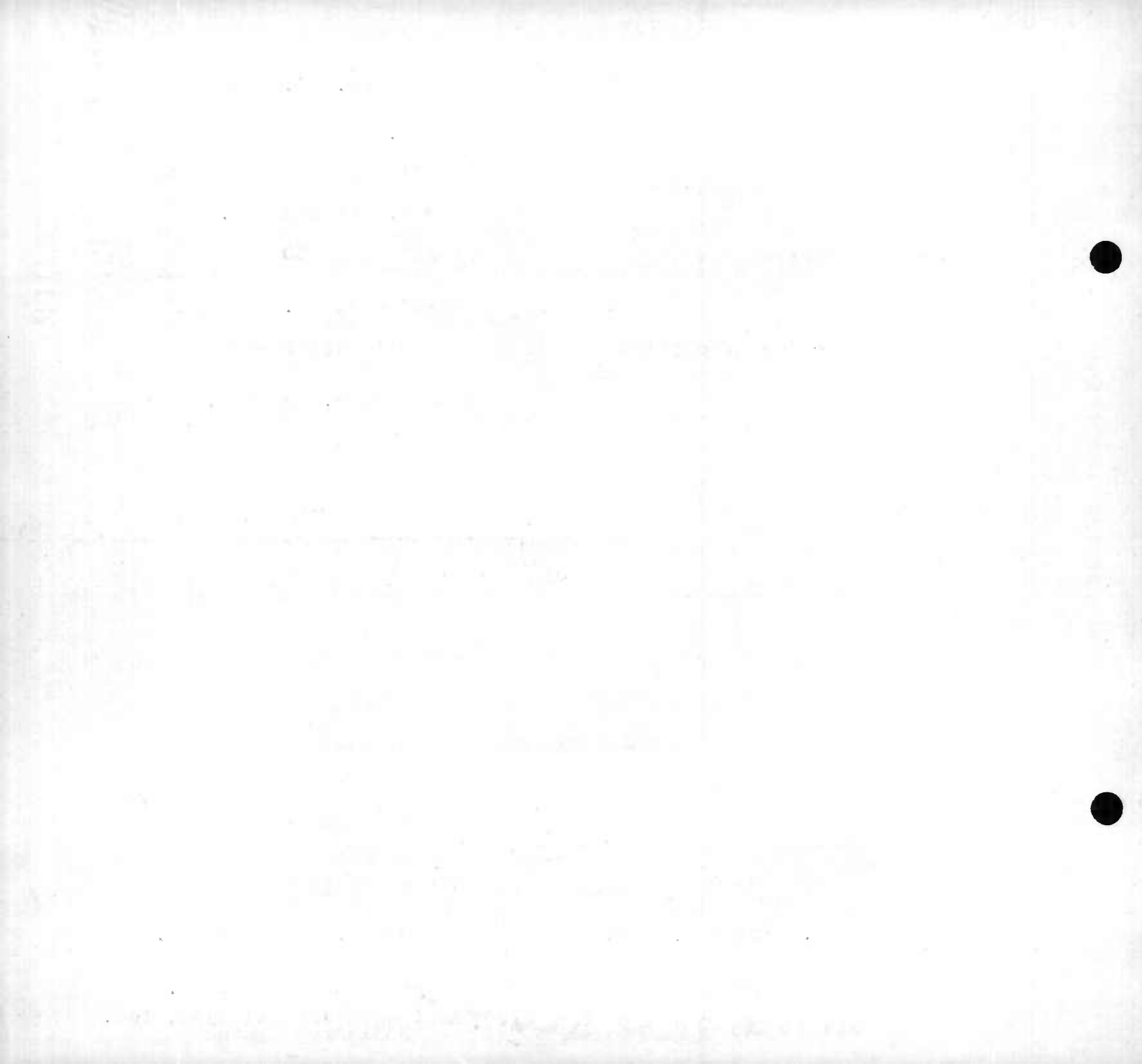
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68-11774 CERTIFICATE OF DEATH

REG. NO. 68-11774

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		EVELYN ELSIE MURPHY		Nov. 20, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 31 99 City Hospital (DOA)				A. STATE Md., 21224	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 29 N. Ellwood Ave.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4/16/18	59	Housewife
		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
		at home	Baltimore, Md.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Euclide Broccolino			Adelia DelGrosso		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
				Fred Murphy, husband, above	
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: hypertensive CVD (B) DUE TO, OR AS A CONSEQUENCE OF: old toxemia of pregnancy (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 10 yrs.?? 10 yrs.??
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 1960 to Nov 20 1968, that (I) (we) lost saw the deceased alive on Nov 13 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Burton V. Lock			23B. DATE SIGNED 11/22/68		23C. PHYSICIAN'S NAME (Type)
23D. ADDRESS 2936 E. Baltimore St.					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	11/25/68	Holy Redeemer Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
NOV 25 1968	Robert E. Taylor	Schimunek Funeral Home, Inc. 3331 Brehms Lane			



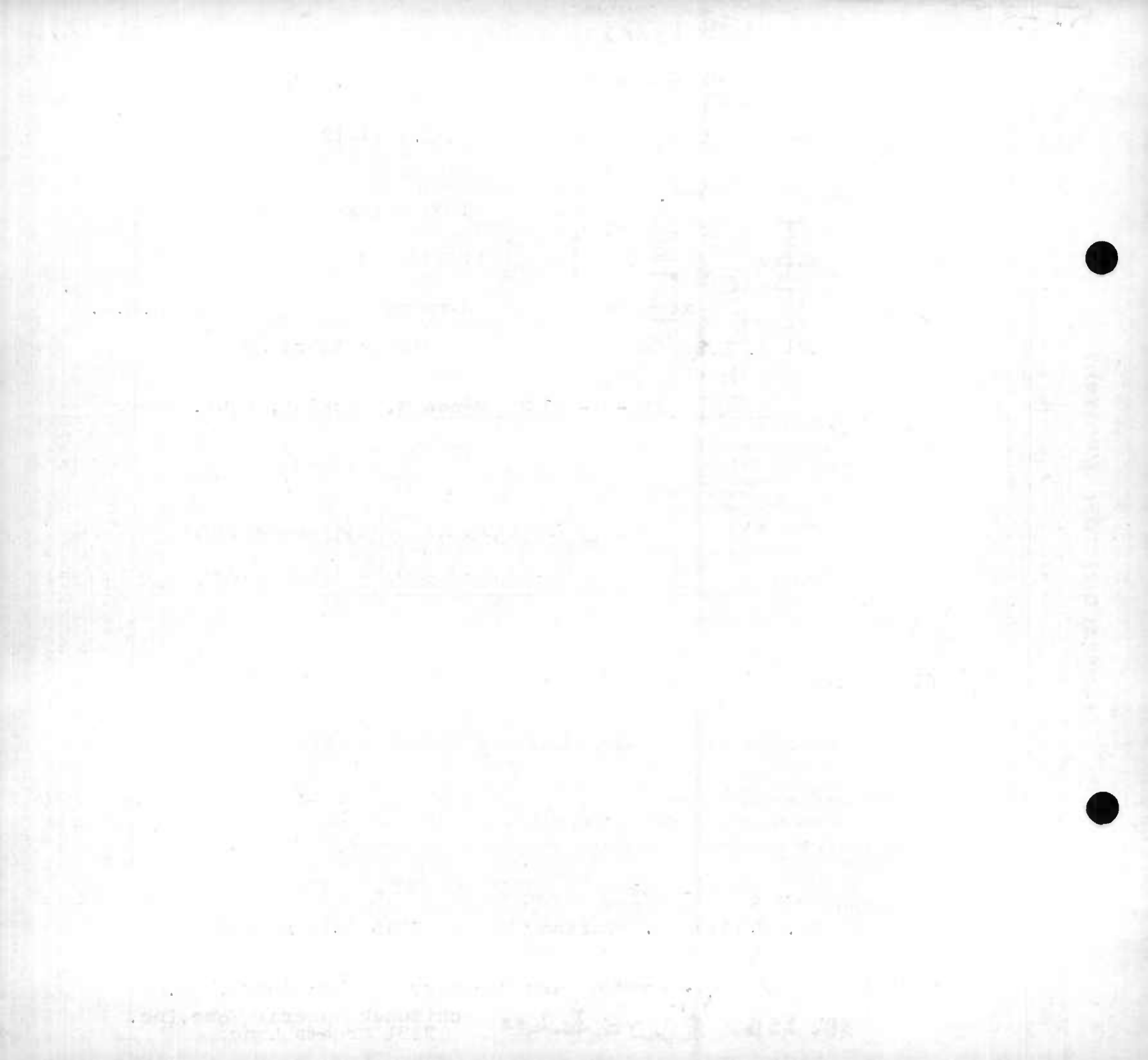
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11775 CERTIFICATE OF DEATH

REG. NO. 68-11775

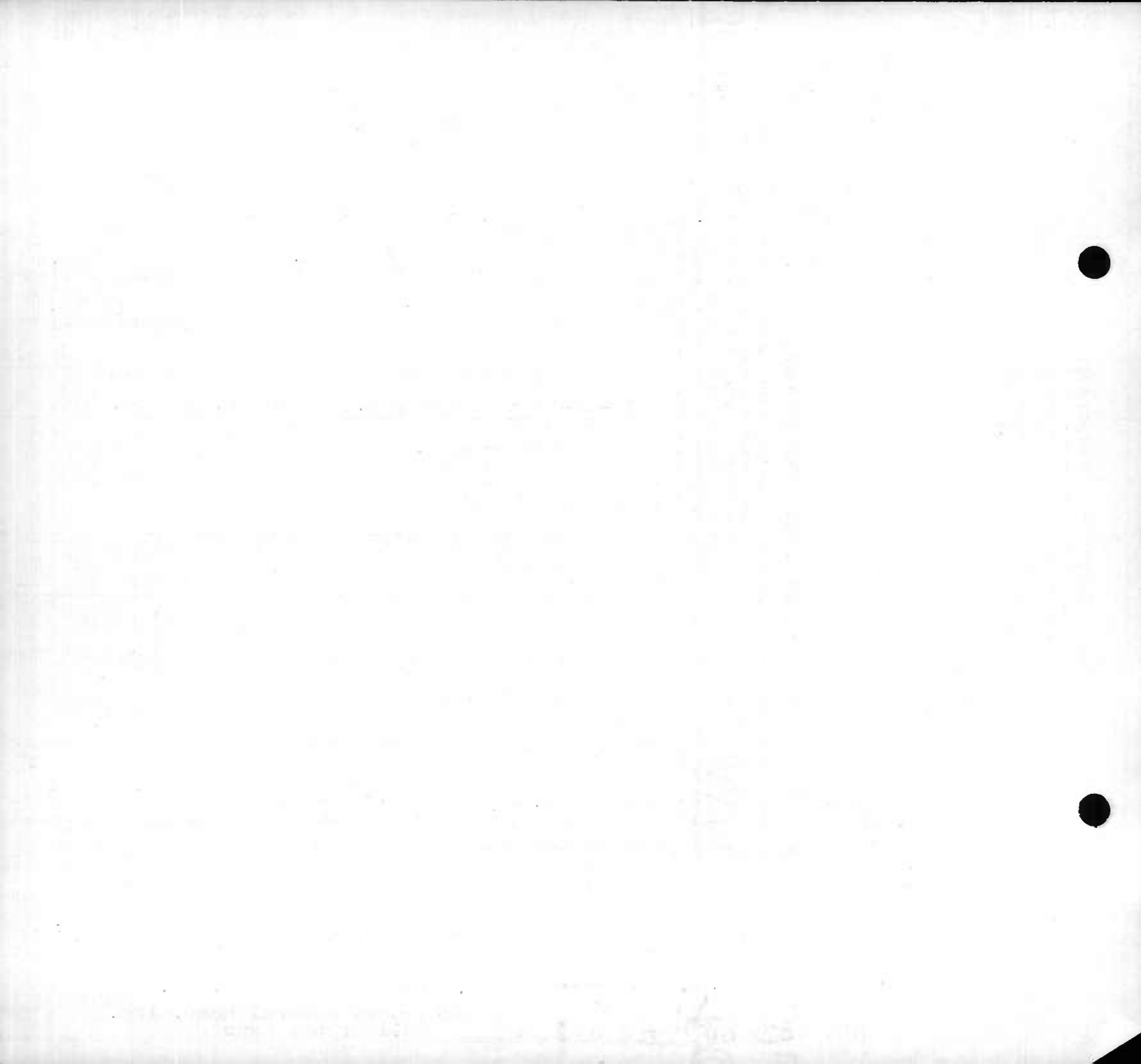
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		AUGUSTA ELISA DEPKIN		Nov. 20, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 6006 Burgess Ave.				A. STATE Md., 21213	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3506 Pelham Avenue	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11/30/1878		89
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		at home		Germany	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Carl H. L. Soefker			U.S.A.		
14. MOTHER'S MAIDEN NAME			17. INFORMANT		
Minner Schramme			Minna B. Werking, dght. above		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			216-01-5315D		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Coronary</i>					
(B) <i>Hypertensive Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>year</i>					
(C) <i>Acute Myocardial Ischemia</i> <i>10-19-68</i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 minutes</i>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
010-20-68		Replaced Gallbladder		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>year</i> 19 <i>50</i> to <i>November 20</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>Nov. 19</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>William L. Fearing</i>				<i>11-22-68</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. William L. Fearing				3025 Belair Road	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11/23/68		Loudon Park Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 25 1968		<i>Robert E. Fearing</i>		Schimunek Funeral Home, Inc.	
				3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11776
BIRTH NO.		68-11776		11/19/68
1. NAME OF DECEASED (Type or Print) <u>ELIZABETH GEISSINGER</u>		2. DATE AND HOUR OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSPITAL</u> <u>33 RD & CALVERT ST</u>		A. STATE <u>PENN. MD.</u> B. COUNTY C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3313 CLIFTON AVE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/94</u>	9. AGE (In years last birthday) <u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>PENN.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Kruegel</u>		
14. MOTHER'S MAIDEN NAME <u>Margaret Weise</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>213-58-3145</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Stanley K. Geissinger, husband, above</u>		
18. <u>485 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Severe bronchopneumonia, bilateral</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>491 X II</u>		Y.S.		
21A. DATE OF OPERATION <u>2</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11/18</u> 19 <u>68</u> to <u>11/19</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> 19 <u>68</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Ronald M. Legum</u>		23B. DATE SIGNED <u>11/19/68</u>		23C. PHYSICIAN'S NAME (Type) <u>RONALD M. LEGUM</u>
23D. ADDRESS <u>UNION MEMORIAL HOSPITAL BALT. MD.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>11/23/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 25 1968</u>		25B. NAME OF REGISTRAR <u>R. L. E. Jones</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

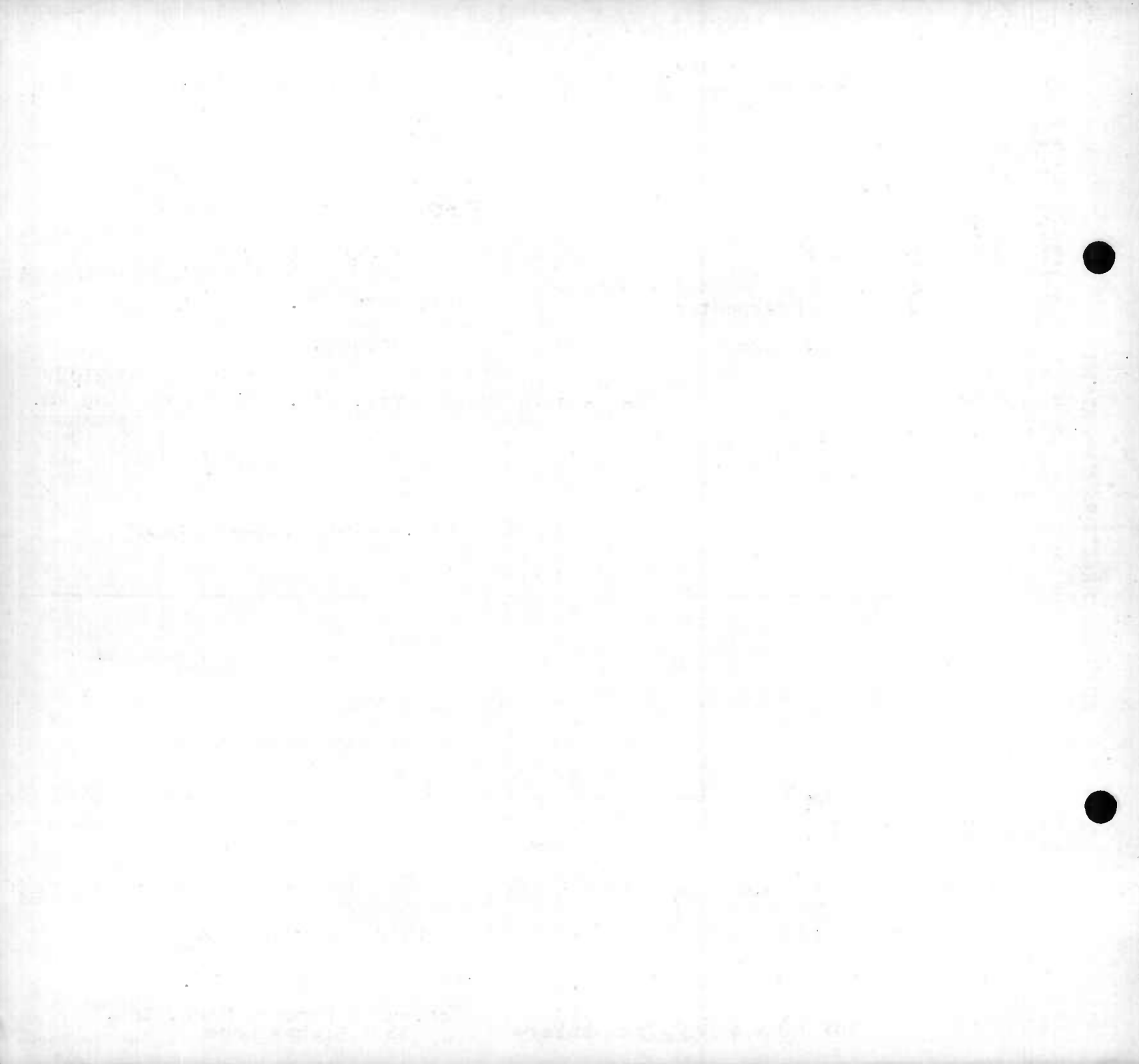
68-11777

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11777

BIRTH NO.		1. NAME OF DECEASED (Type or Print) DANIEL H. BERRY		2. DATE AND HOUR OF DEATH NOV. 18, 1968 6:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL			C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 3300 BRENDAN AVE.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-19-1984	9. AGE (In years last birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Carpenter		10B. KIND OF BUSINESS OR INDUSTRY self-employed		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Henry Berry			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-01-2351A		17. INFORMANT Earl Berry, son, 6308 Golden Ring Rd.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE MYOCARDIAL INFARCTION ASCVD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from NOV. 14, 1968 to NOV. 19, 1968 , that we (we) last saw the deceased alive on NOV. 18, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. It (We) (did) not view the body after death.					
23A. SIGNATURE PONCIANO V. SALUD				23B. DATE SIGNED NOV. 18, 1968	
23C. PHYSICIAN'S NAME (Type) PONCIANO V. SALUD		23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/68		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.			
25D. ADDRESS 3331 Brehms Lane					

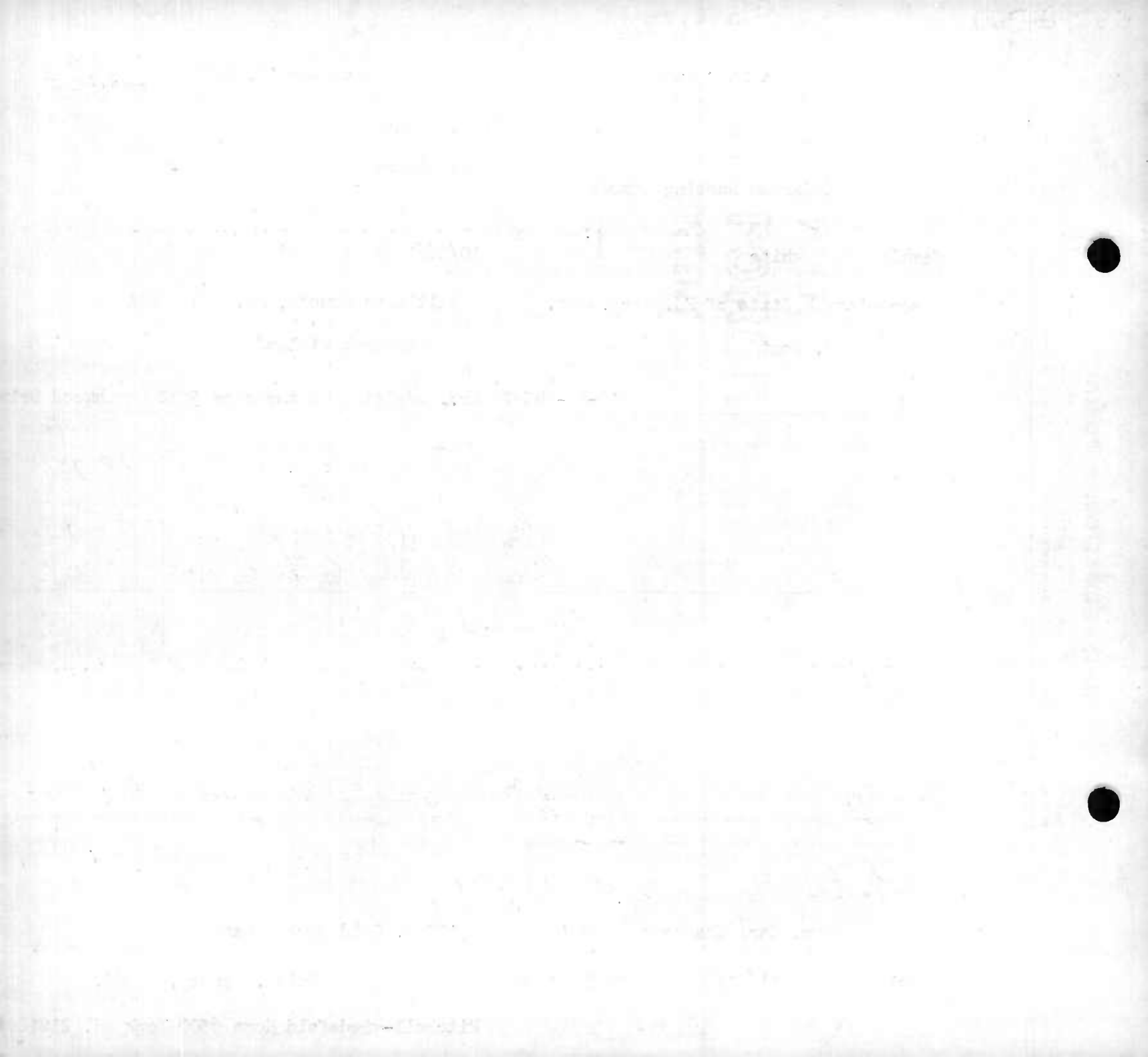


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11778 CERTIFICATE OF DEATH

REG. NO. 68-11778

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Anna Mary Vogt		November 18, 1968 10:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Anderson Nursing Home				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3604 Mohawk Avenue	
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/1887	9. AGE (In years last birthday) 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary State of Md. Work. Comp.
			11. BIRTHPLACE (State or foreign country) Baltimore County, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John P. Vogt			14. MOTHER'S MAIDEN NAME Margaret Wieland		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 218-44-6454T		17. INFORMANT Mrs. Adelaide Weathersbee 5832 Northwood Drive
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412-13 I			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arterio Sclerotic Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis		2 yrs.
			(C) Chronic Infections Arthritis		- 5 yrs
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 4200 II			Generalized Arterio Sclerosis		
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 25 1967 to Nov. 18 1968, that (I) last saw the deceased alive on Nov. 18 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Earl L. Chambers				23B. DATE SIGNED 11/18/68	
23C. PHYSICIAN'S NAME (Type) Dr. Earl Chambers				23D. ADDRESS 100 W. Cold Spring Lane	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 11/21/68		24C. NAME of CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION Balto. County, Md.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11779 CERTIFICATE OF DEATH

REG. NO.

68-11779

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Wilcox, Miss Martha</i>		2. DATE AND HOUR OF DEATH <i>11-20-68</i> <i>6 30 p</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Keswick - Home for Incapables</i> FULL NAME OF HOSPITAL OR INSTITUTION <i>91</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>700 W. 40th Street Baltimore, Maryland 21211</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>700 W. 40th Street</i>		13. FATHER'S NAME <i>Louis Napoleon Wilcox</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 13, 1882</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-32-1539</i>		17. INFORMANT <i>Hancy Fairchild - R.N. Records: Keswick</i> ADDRESS <i>700 W. 40th Street 21211</i>	
18. <i>412.21 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <i>Hypertensive Cardio-Vascular Disease</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>443X II</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>—</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>—</i> (C) <i>—</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>January 23 1961</i> to <i>January 20 1968</i> , that (I) (we) lost saw the deceased alive on <i>January 19 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. Grafton Hersperger M.D.</i>				23B. DATE SIGNED <i>November 21, 1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>W. Grafton Hersperger, M.D.</i>		23D. ADDRESS <i>700 West 40th Street, Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>11/22/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Olivet</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 25 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home</i>			
25D. ADDRESS <i>6500 York Rd. 21212</i>					

Female White

None

Louis Hapton Wilcox

3 mm I Ves

Long 14-15

20-2-1939 Recd. Kew

to W. H. H.

Thymus *carolinensis*
Palmer

Handwritten 1939

Collected by

Jan 12, 1939

Handwritten

A. 2. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11780				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11780	
1. NAME OF DECEASED (Type or Print) JOHN N. BRUCE				2. DATE AND HOUR OF DEATH November 21/1968 5:05 PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 308 LONG ISLAND AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/28/1898	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME George R. Bruce				14. MOTHER'S MAIDEN NAME Loan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220 207296		17. INFORMANT HOSPITAL RECORDS		ADDRESS	
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE cardiac arrest DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5PM.	
				(B) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF:		11/21/1968	
				(C) coronary insufficiency		1965	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 21, 1968 to November 21, 1968 , that (I) (we) last saw the deceased alive on November 21, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Eurique Ellenbogen MD				23B. DATE SIGNED 11/21/68		23C. PHYSICIAN'S NAME (Type) Eurique Ellenbogen MD	
23D. ADDRESS Union Memorial Hospital.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-25-1968		24C. NAME OF CEMETERY or CREMATORY Bellair Memorial Gardens		24D. LOCATION (City, town, or county) (State) Harford County - Md.	
25A. DATE RECEIVED NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Edw. R. MacRath - 301 Frederick Rd		ADDRESS	

WISCONSIN
1/23/1947
HALL WHITE
*
UNION MEMORIAL HOSPITAL
308 FOND DU LAC AVE
EAST WAUWATOSA
WISCONSIN

RECEIVED
UNION MEMORIAL HOSPITAL
JAN 23 1947

FOR THE
UNION MEMORIAL HOSPITAL
EAST WAUWATOSA
WISCONSIN
JAN 23 1947

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11781

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11781

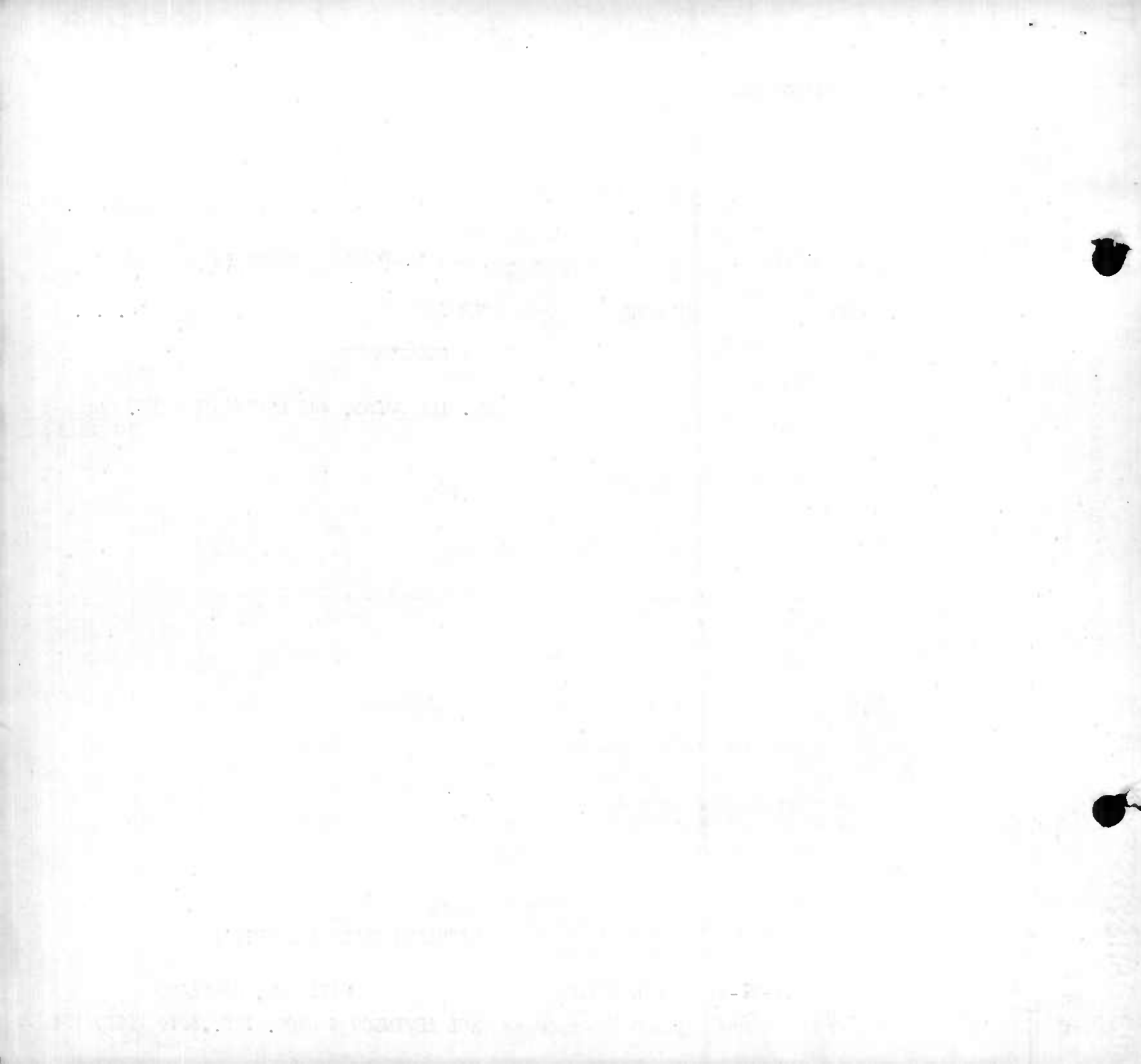
BIRTH NO.		1. NAME OF DECEASED <i>Fred M. Hershberger</i>		2. DATE AND HOUR OF DEATH <i>11/21/68</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Maryland General Hospital</i>		4. USUAL RESIDENCE (Where deceased lived if institution residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN <i>Edgemere</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>Baltimore, Maryland</i>		E. STREET AND NUMBER <i>2624 Manor Ave</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>12/25/04</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Nelson Box Co.</i>		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>	
13. FATHER'S NAME <i>George Hershberger</i>		14. MOTHER'S MAIDEN NAME <i>Martha Benneer</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>24056757</i>		17. INFORMANT <i>Previous admission chart</i>	
18. <i>150X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>BRONCHO PNEUMONIA, BICAT</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Melanotic Ca of Esophagus</i> <i>CARCINOMATOSIS</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>CARCINOMA of ESOPHAGUS</i> (C) <i>CARCINOMA of ESOPHAGUS</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>11/19/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>obstructed Esophagus</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/12/68</i> 19 to <i>11/21/68</i> 19, that (I) (we) last saw the deceased alive on <i>11/21/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M.L.S. Brown, M.D.</i>		23B. DATE SIGNED <i>11/21/68</i>		23C. PHYSICIAN'S NAME (Type) <i>M.L.S. Brown, M.D.</i>	
23D. ADDRESS <i>Maryland General Hospital</i>		23E. ADDRESS <i>Maryland General Hospital</i>		23F. ADDRESS <i>Maryland General Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/25/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. LOCATION <i>Baltimore, Maryland</i>		24F. LOCATION <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>John J. Duda, 7922 Wise Ave. Dundalk, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W. 200		68-11782		BALTIMORE CITY HEALTH DEPT		68-11782	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ESTHER		2. DATE AND HOUR OF DEATH 11/21/68 9:40 P.M.		REG. NO.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hosp (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5713 Chatham Rd Lutherville			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH XXXXXX/XXXX/XXXX	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT MR. LEE SACHS, 400 EQUITABLE BLDG.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.421 250.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 175 CVD & Diabetes mellitus				CAUSE OF DEATH CV D (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 11/15 19 68 to 11/21 19 68 , that (I) (we) last saw the deceased alive on 11/15 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature]				23B. DATE SIGNED 11/21/68		23C. PHYSICIAN'S NAME (Type) [Signature]	
23D. ADDRESS MARYLAND GENERAL HOSPITAL				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 11-22-68		24C. NAME of CEMETERY or CREMATORY BETH TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968	
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-436				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11783	
68-11783				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HARRY FELDERSTEIN				2. DATE AND HOUR OF DEATH Nov. 22, 1968 10:10 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Pk. Drive				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE NEW YORK B. COUNTY V-29 C. CITY OR TOWN PITTSFORD D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3656 B Monroe Avenue Temple Gardens/			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/08	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10B. KIND OF BUSINESS OR INDUSTRY Music Store		11. BIRTHPLACE (State or foreign country) NY, ROCHESTER		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Felderstein				14. MOTHER'S MAIDEN NAME Gertrude Michaels			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 115-20-0870		17. INFORMANT ADDRESS PARSKY FUNERAL HOME, INC. 1125 ST. PAUL ST. ROCHESTER, NEW YORK 14621			
18. 2050 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Septic shock (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute myelogenous leukemia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ 2043 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 2 yrs.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept. 22 1968 to Nov. 22 1968 , that (I) (we) last saw the deceased alive on Nov. 22 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Steven Kanner, M.D. DEGREE				23B. DATE SIGNED 11/22/68		23C. PHYSICIAN'S NAME (Type) P. Steven Kanner, Surgeon (R) DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 11-24-68		24C. NAME OF CEMETERY or CREMATORY MT. HOPE		24D. LOCATION (City, town, or county) (State) ROCHESTER, NEW YORK	
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Fairbairn		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

10-423		68-11784		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. _____	
BIRTH NO. _____				1. NAME OF DECEASED (Type or Print) <i>Samuel Collector</i>			
2. DATE AND HOUR OF DEATH <i>22 November 1968 8:00</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Sinai Hospital of Baltimore</i> <i>42</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>3717 Park Heights Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/12/82</i>	9. AGE (In years lost birthday) <i>86</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TAILOR</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>SHOP</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>MOSES COLLECTOR</i>				14. MOTHER'S MAIDEN NAME <i>BERNICE FOX</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>LONG GREEN ROAD</i> <i>MR. ALBERT COLLECTOR, LONG GREEN, MD, 21092</i>			
18. <i>193.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Abdominal Carcinomas</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>199.2 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <i>5 November 1968</i> to <i>22 November 1968</i> , that (we) last saw the deceased alive on <i>22 November 1968</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) <i>not</i> view the body after death.							
23A. SIGNATURE <i>Morris Ostroff, MD</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>22 Nov 1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>MORRIS OSTROFF, MD</i>				23D. ADDRESS <i>SINAI HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11-24-68</i>		24C. NAME of CEMETERY or CREMATORY <i>BALTIMORE HEBREW</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 25 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Sadowski</i>		25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN RD.</i>			

M.
admission)

68-11784

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1A-651

68-11785

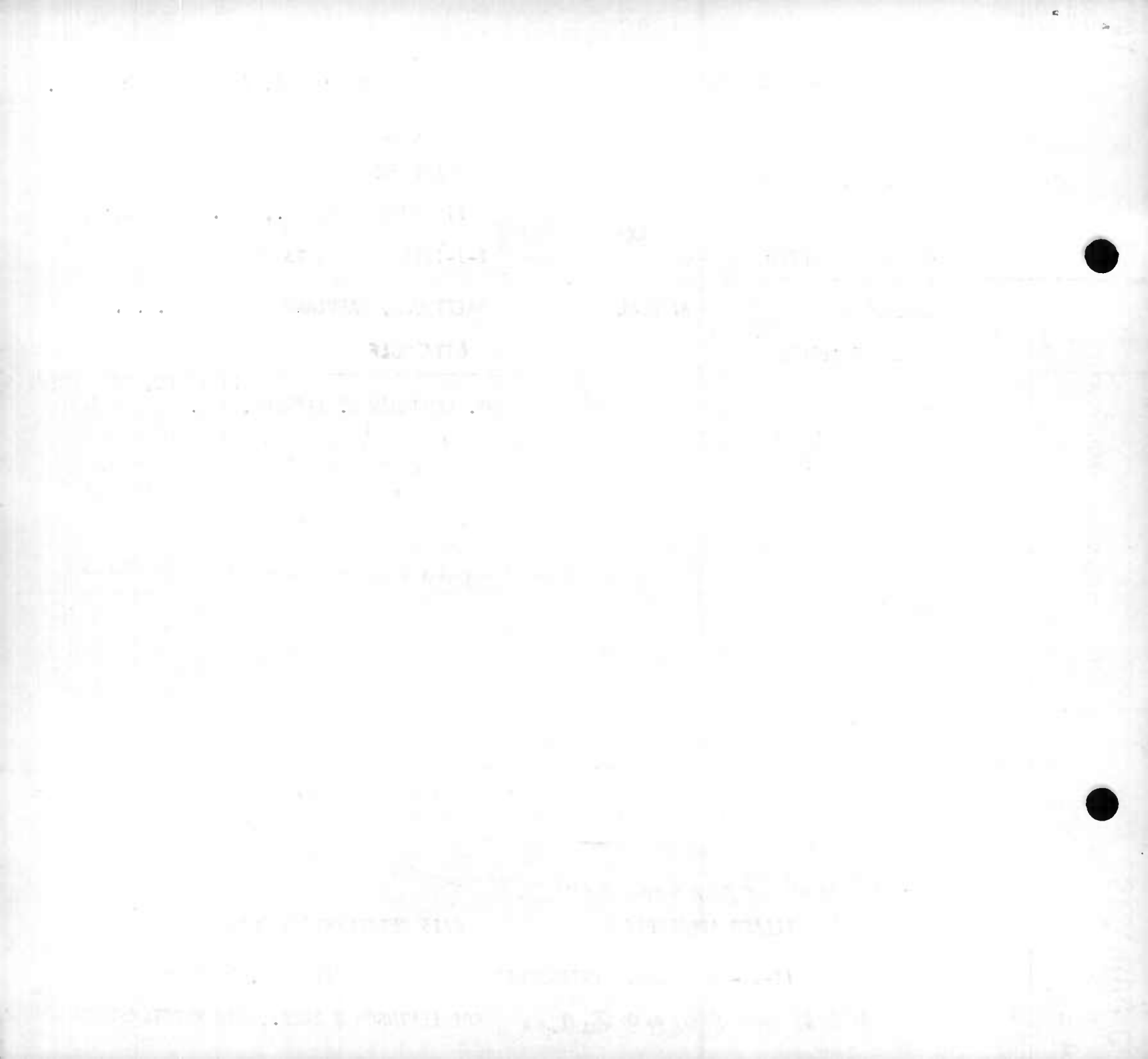
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11785

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SAMUEL ARONOVITCH		2. DATE AND HOUR OF DEATH 11-21-68 10:25P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3437 Lynnew Ave. 15	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-1908	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR CRAFTSMAN		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) RIGA, RUSSIA	
13. FATHER'S NAME JACOB ARONOVITCH		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-54-4235		17. INFORMANT MR. MORRIS ARONOVITCH, 4404 OLD COURT RD. #8	
18. I 151.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Stomach cancer		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Stomach cancer (B) DUE TO, OR AS A CONSEQUENCE OF: Anterior pituitary (C) _____			
18. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 151X					
19A. DATE OF OPERATION 11-8-1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED POOR		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-3 19 68 to 11-21 19 68 , that (I) (we) last saw the deceased alive on 11-21 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Nagayoshi				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) M. NAGAYOSHI		23D. ADDRESS SINAI Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-24-68		24C. NAME OF CEMETERY or CREMATORY LUBAWITZ NUSACH ART INC.	
24D. LOCATION (City, town, or county) ROSEDALE, MARYLAND		24E. LOCATION (State) ROSEDALE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11787
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) ENOCH H. SMITH		2. DATE AND HOUR OF DEATH 11-21-68 11:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 36 FRANKLIN SQUARE HOSPITAL		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 1001 W. LOBBARD ST. # 23		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-92	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) KENTUCKY
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME FRANK SMITH		14. MOTHER'S MAIDEN NAME LIZA SIZEHORE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 403-14-1293A		17. INFORMANT HOSPITAL Record ADDRESS UTAI RUANGWIT, M.D. FRANKLIN SQUARE HO.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) 250.9 I 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 260X II		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE CARDIO- VASCULAR DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: DIABETES MELLITUS (C) _____		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11-11-68 to 11-21-68 , that (I) (we) last saw the deceased alive on 11-21-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Utai Ruangwit, M.D.				23B. DATE SIGNED 11-21-68
23C. PHYSICIAN'S NAME (Type) UTAI RUANGWIT, M.D.		23D. ADDRESS FRANKLIN SQUARE HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-25-68	24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem Park Cem	24D. LOCATION (City, town, or county) (State) Glen Burnie, Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Farber	25C. FUNERAL DIRECTOR ADDRESS Thomas J Kenny Inc 1600 Hollins St	

FRANKLIN SQUARE HOSPITAL

1001 W LOMBARD ST

W

11-12

RETIRED

KENTUCKY

FRANK SMITH

LISA SIZEMORE

NO

1001 W LOMBARD ST FRANKLIN SQUARE

Hypertensive Cerebral
Vascular Disease
Diabetic Mellitus

11-12

11-12

11-12

Wm. Randolph, MD

11-12

FRANKLIN SQUARE HOSPITAL

Wm. Randolph, MD

Released By H.O.
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11788 CERTIFICATE OF DEATH

REG. NO.

68-11788

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM COUSIN		2. DATE AND HOUR OF DEATH Nov. 5, 1968 6:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 13-02		
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF MD HOSP			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2028 PARK AVE		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/05	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cloth Cutter		10B. KIND OF BUSINESS OR INDUSTRY Clothing Ind (R)		11. BIRTHPLACE (State or foreign country) Whitegate, VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME IMMANUEL COUSINS		14. MOTHER'S MAIDEN NAME FANNIE Mc CALLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 226-03-3601		17. INFORMANT Irene Ralston	
18. E 887 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH BILAT PNEUMONIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: WOUND INFECTION @ HIP (B) FX @ HIP (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 2 WKS 3 WKS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E 904.0 II					
19A. DATE OF OPERATION 10/29 & 10/30		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED IMPECTED FX HIP, 2° PROSTHETIC INFECTION		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) HOME	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 10/5/68		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL IN HOUSE - FX HIP	
22. I certify that (I) (this hospital) attended the deceased from 10/5 to 10/5 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward R. Cohen, M.D.		23B. DATE SIGNED 11/5		23C. PHYSICIAN'S NAME (Type) EDWARD R. COHEN M.D.	
23D. ADDRESS Univ. of Md Hosp		24. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 11/9/68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery Baltimore		24D. LOCATION (City, town, or county) (State) Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR J.B. Johnson	
				ADDRESS Entaw Pl. Balt. Md	

no — are as follows:
Irene (sister)
Fannie Mc Call
Cloth Cutter, 1-1/2 West 14th St, N.Y.

Butler 11/18 Mr. Carey, Cemetery Baltimore
Maryland
J.R. Thomas, Esq., 61 East 7th St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 14
BIRTH NO.		68-11789		68-11789
1. NAME OF DECEASED (Type or Print)		William M. Augustine		2. DATE AND HOUR OF DEATH Nov. 22, 1968 1 ¹⁴ A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore Co</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>4940 Eastern Ave Baltimore, Maryland #24</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <i>Male</i>		E. STREET AND NUMBER <i>7937 Charlesmont Road</i>		
6. RACE <i>White</i>		8. DATE OF BIRTH <i>7/27/33</i> 9. AGE (in years, lost birthday) <i>35</i>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (in years, lost birthday) <i>36</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Good Samaritan Hospital</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Jesse Augustine</i>		14. MOTHER'S MAIDEN NAME <i>Susan Kullman</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Korean War</i>		16. SOCIAL SECURITY NO. <i>213-30-8657</i>		
		17. INFORMANT <i>BCH Medical Records</i> ADDRESS <i>4940 Eastern Ave Balto.</i>		
18. <i>207.0</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute leukemia</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute leukemia</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>4 wks.</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. <i>204.3</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>—</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>
21F. HOW DID INJURY OCCUR? <i>—</i>				
22. I certify that (I) (this hospital) attended the deceased from <i>Nov. 6 1968</i> to <i>Nov. 22 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov. 21 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Hubert W. Gerry M.D.</i>		23B. DATE SIGNED <i>Nov. 22, 1968</i>		
23C. PHYSICIAN'S NAME (Type) <i>Hubert W. Gerry M.D.</i>		23D. ADDRESS <i>4940 Eastern Ave. Balt. Md</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>NOV 25 1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Rosary Cemetery</i>
24D. LOCATION <i>Baltimore, Maryland</i>		25A. DATE RECEIVED <i>NOV 25 1968</i>		
25B. NAME OF REGISTRAR <i>Robert E. Taniguchi</i>		25C. FUNERAL DIRECTOR <i>Joseph N. Zannino 263 S</i>		



46-11-30

djs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-200

68-11780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11780

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RICE, BEARL I.

2. DATE AND HOUR OF DEATH

11/20/68

12:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE

53-00

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

BALTIMORE

YES ☐NO ☒

E. STREET AND NUMBER

109 NORTH AVONDALE ROAD 21222

5. SEX

6. RACE

7. MARRIED ☒NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years lost birthday)

If Under 1 Yr. Months

Days

If Under 24 Hrs. Hours

Min.

FEMALE

NEGRO

WIDOWED ☐DIVORCED ☐

12-23-11

56

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

SOUTH CAROLINA, WINNSBORO

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES ~~TABLETIX~~ TOADLEY

14. MOTHER'S MAIDEN NAME

EUNICE RATERY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

BCH: RECORDS 4940 EASTERN AVE. BALTO. MD. 21224

18.

412.3 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

420.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Now

Now

No

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-3 19 68 to 11/20 1968 and that (I) (we) last saw the deceased alive on 11/20 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

JOHN COHEN M.D.

DEGREE

23D. ADDRESS

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE BALTO. MD. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

Burial

11-26-68

Middlesex Ch. Cemetery

Winnsboro, South

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

NOV 25 1968

Robert E. Sanborn

MORTON & DYETT F.H.

Bristol

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11791

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) THOMAS BOYKINS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 23 68 7:30 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 726 Lennox St.		3. DATE PRONOUNCED DEAD Month Day Year Hour November 23, 1968 7:30 a.m.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 6-8-1940		10. AGE (In years last birthday) 28	
11. BIRTHPLACE (State or foreign country) Sumpter S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes		17. SOCIAL SECURITY NO. 216-36-6020	
18. INFORMANT Ruth Boykins		ADDRESS 726 Lennox St.	
19. CAUSE OF DEATH 3459 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Epilepsy ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 353.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Nov. 23, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-27-68	
24C. NAME OF CEMETERY or CREMATORY Balto. NAT.		24D. LOCATION (City, town, or county) (State) Balto.	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 28 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR MORTON + Dyett - 175		ADDRESS	

Yes
Singer, S.C. v. sa. Hennis Perkins
Lola Perkins
Singer, S.C. Perkins All known

WILLIAM HENNING

WILLIAM HENNING

14

Baltimore

Baltimore

Baltimore

Horton - Jett - 1901

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11792		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11792	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARY L. RICE		November 20, 1968	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
00 1043 Argyle Avenue		MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1043 Argyle Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 7-20-1899	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Henry Williams			14. MOTHER'S MAIDEN NAME Ellen Cole		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Josephine Jones 640 N. Carey St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I Acute coronary occlusion Sudden		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Sudden UNKNOWN	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 420.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 10 1968 to Nov 20 1968, that (I) (we) last saw the deceased alive on Nov 20 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William H. Watts				23B. DATE SIGNED 11/22/68	
23C. PHYSICIAN'S NAME (Type) William H. Watts				23D. ADDRESS 515 N. Arlington Ave Baltimore Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-25-68		24C. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11793

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(AKA John Devlin)

(Type or Print)

(George) GOERGE HERNDON, JR.

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

October 20, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

October 20, 1968

3:45 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

E. STREET AND NUMBER

2222 Lynhurst Street

6. SEX

7. RACE

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

Male

Negro

9. DATE OF BIRTH

10. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

2-13-1937

31

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

~~MABLE MC KINNEY~~ GEORGE HERNDON, SR.14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Motor Sales

15. MOTHER'S MAIDEN NAME

MABLE MC KINNEY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL
SECURITY NO.

216-34-6350

18. INFORMANT

ADDRESS

Mrs. Lillie Peaker 2705 Presbury St.

19. *E965X*

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Gunshot wound of chest
DUE TO, OR AS A CONSEQUENCE OF:(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

MEDICAL CERTIFICATION

E981X

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

car

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

500 block Normandy Street

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

10-20-68

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot while sitting in car

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 8, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-23-68

24C. NAME OF CEMETERY or CREMATORY

Mount Auburn Cem.

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 25 1968

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

MORTON & DYETT F.H. 1701 Laurens St.

554-1-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11794

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11794

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BERNARD SPRIGGS		11/21/68 11:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL				A. STATE BALTIMORE B. COUNTY BALTIMORE CITY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
				E. STREET AND NUMBER 729 HARFORD ROAD 21202	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/03	9. AGE (In years last birthday) 65	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME William Spriggs		
14. MOTHER'S MAIDEN NAME JAHK TRAVIS			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 216-10-2749			17. INFORMANT Ethel Spriggs		
18. CAUSE OF DEATH			ADDRESS 729 Harford Rd		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.3 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF: 5 hrs		
			(B) Hypertensive ASCVD DUE TO, OR AS A CONSEQUENCE OF: 10 yrs		
			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 443X II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from Jan 1963 to Nov 21 1968, that (I) last saw the deceased alive on Nov 21 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard W. Light				23B. DATE SIGNED 11/21/68	
23C. PHYSICIAN'S NAME (Type) Richard W. Light				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/25/68		24C. NAME OF CEMETERY or CREMATORY Carrowman, FR	
24D. LOCATION Lanel, Md		24E. DATE RECEIVED IN HEALTH DEPT. NOV 25 1968		24F. NAME OF REGISTRAR Robert E. Johnson	
24G. FUNERAL DIRECTOR Joseph J. Locks		24H. ADDRESS 1304h. Central			

10-1-1917

Internal Revenue
Department

10-1-1917

Richard W. Light
James Hopkins Hopkins

FUNERAL DIRECTOR: IMPORTANT

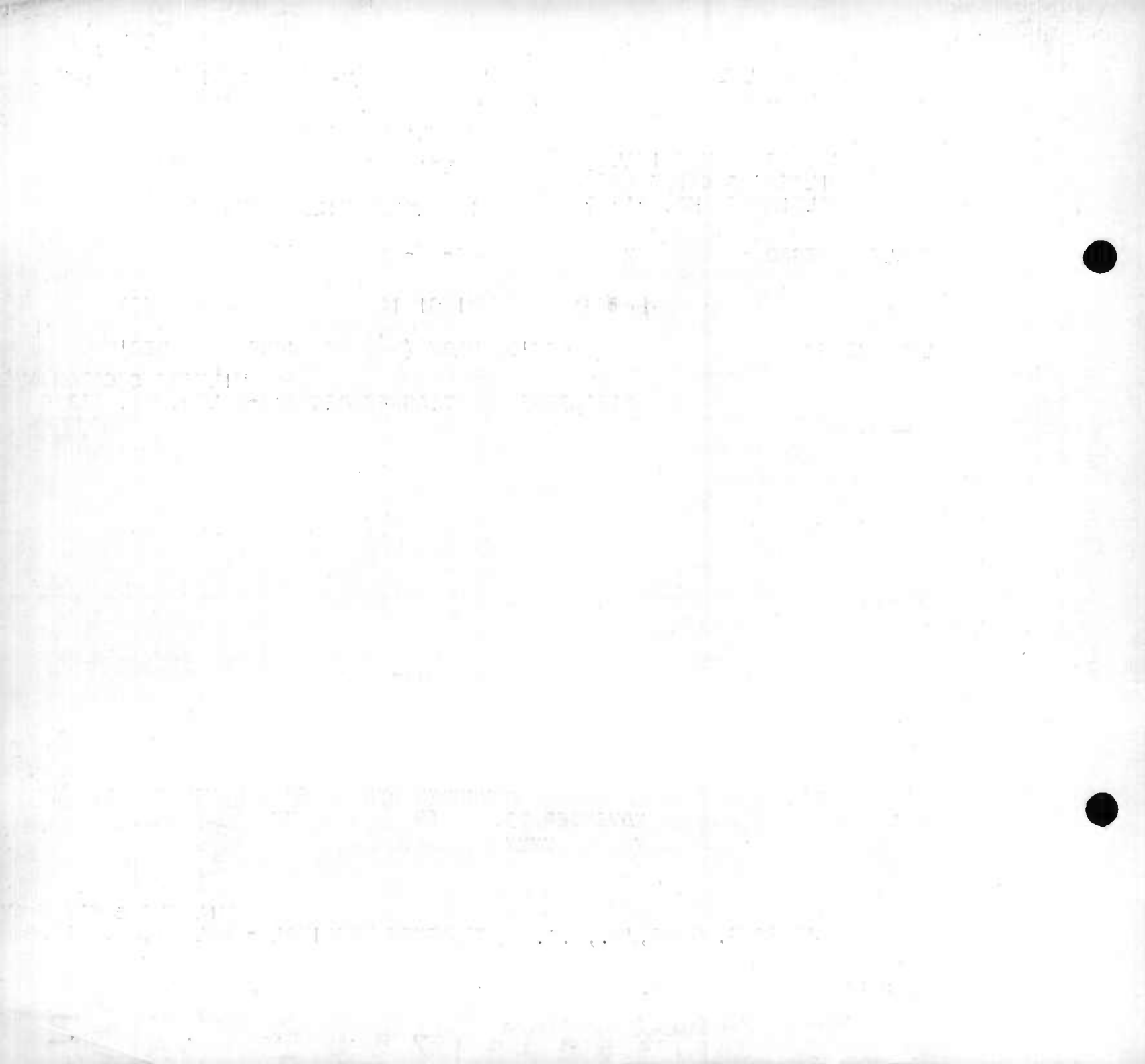
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68-11795 CERTIFICATE OF DEATH

REG. NO. 68-11795

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JONES, LULA		2. DATE AND HOUR OF DEATH NOVEMBER 23, 1968 2:05 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21229			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
		E. STREET AND NUMBER 104 NORTH HILTON ST.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-06-03	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10B. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LEVY JONES			
14. MOTHER'S MAIDEN NAME DEC'D MARY () JONES		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 215103985		17. INFORMANT WILKENS & CATON AVE ST. AGNES RECORDS-BALTO., MD. 21229			
18. 431.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF:			
		(B) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
19. 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from NOVEMBER 8TH 19 68 to NOVEMBER 23, 1968 , that X (we) last saw the deceased alive on NOVEMBER 23, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) XXXX view the body after death.					
23A. SIGNATURE JAMES G. KANE, JR., M.D.		23B. DATE SIGNED 11/23/68		23C. PHYSICIAN'S NAME (Type) JAMES G. KANE, JR., M.D.	
23D. ADDRESS ST. AGNES HOSPITAL - BALTO., MD. 21229		23E. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 11/27/68		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
24D. LOCATION Baltimore, Maryland		24E. ADDRESS 11/23/68			
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.	

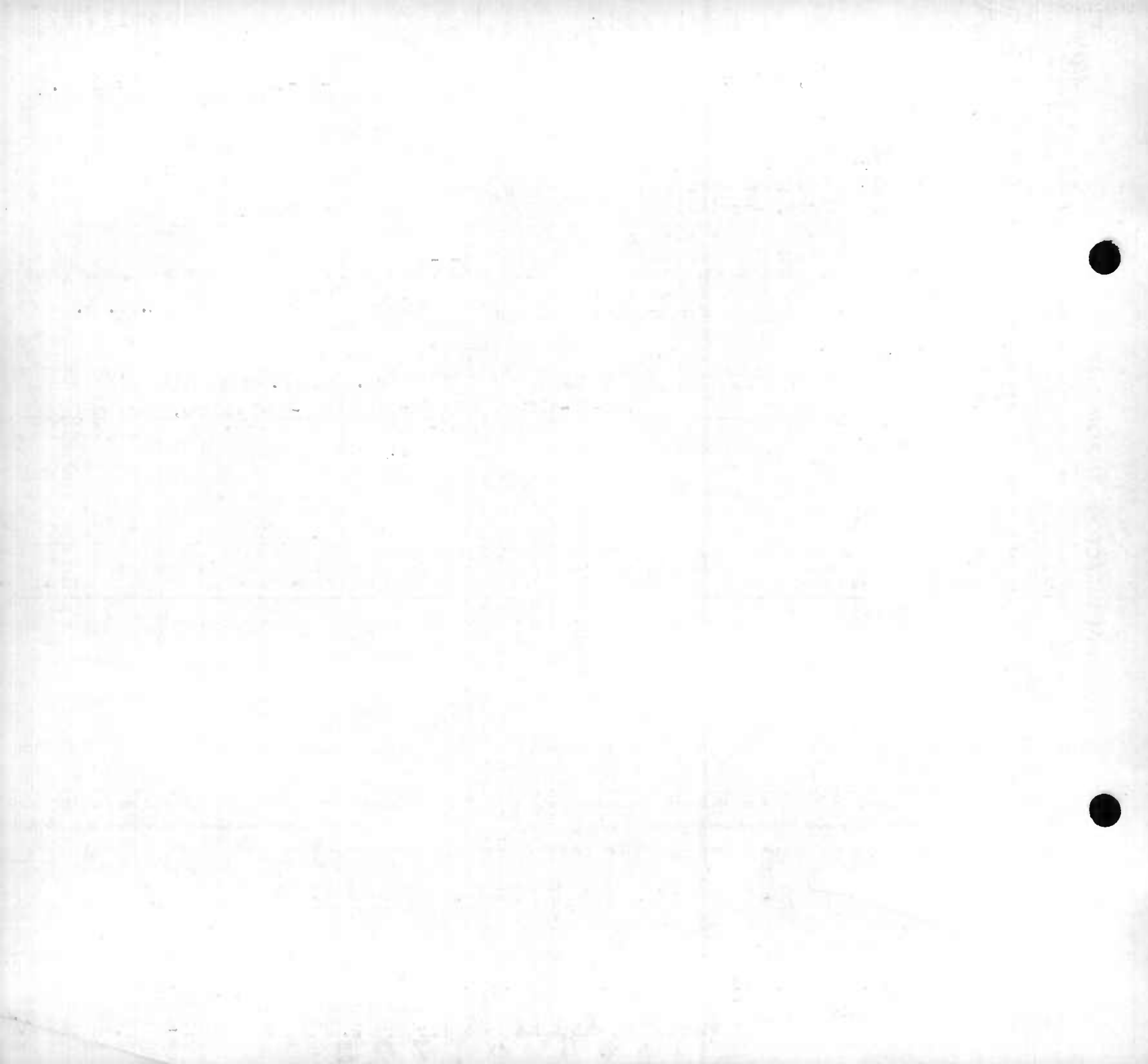


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11796

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Turpin, Waters		2. DATE AND HOUR OF DEATH 11-19-68 9:00 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-10		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital 1514 Division Street Baltimore, Maryland			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4404 The Alameda		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-10	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor		10B. KIND OF BUSINESS OR INDUSTRY Morgan State College		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Simon Turpin			
14. MOTHER'S MAIDEN NAME Rebecca Waters				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 727-01-4129		17. INFORMANT Mrs. Jean F. Turpin (Wife) ADDRESS 4404 The Alameda - Baltimore, Maryland			
18. I 153.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH port-operative shock Carcinoma of Colon (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intestinal Obstruction (B) DUE TO, OR AS A CONSEQUENCE OF: Stomach Carcinoma of Colon (C) Stomach Carcinoma of Colon			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 days		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 11-17-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-8-68 19 to 11-19-68 19, that (I) (we) last saw the deceased alive on 11-19-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Franklin Phillips M.D. DEGREE				23B. DATE SIGNED 11/19/68	
23C. PHYSICIAN'S NAME (Type) Franklin Phillips DEGREE				23D. ADDRESS 358 N. W. 10th St. Balt. Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/68		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR Robert E. Nutter			
25A. DATE RECEIVED NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Nutter		25C. FUNERAL DIRECTOR Herbert E. Nutter ADDRESS 3035-37 W. North Ave	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11797

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRY STEWART Jr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 19, 1968		Hour 1:00 P.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2329 Linden Avenue (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 19, 1968		Hour 1:00 P.
6. SEX Male		7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1/16/1929		10. AGE (In years last birthday) 38	E. STREET AND NUMBER 2329 Linden Avenue	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry W. Stewart Sr.
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		14B. KIND OF BUSINESS OR INDUSTRY Laundry		15. MOTHER'S MAIDEN NAME Hattie Duckett
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. 220-20-3598		18. INFORMANT ADDRESS Mabel Grant-3912 Bereva Road
19. 011.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Tuberculosis		CAUSE OF DEATH Pulmonary Tuberculosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED November 19, 1968
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/68		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave.
24D. LOCATION (City, town, or county) (State) Baltimore Maryland				

Paul M. M. M.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11798 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11798

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MAMIE WILLIAMS		NOV 22 1968 6 ⁴⁵ PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2111 Garrison Blvd.	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-9-01	9. AGE (In years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Cumberland Co. Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT DEANE			
14. MOTHER'S MAIDEN NAME MITTIE HILL		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 219-30-8286		17. INFORMANT Mrs. James Kimbrough-P.O. Box-143 Cumberland Co. Va.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE UREMIA.					
(B) DUE TO, OR AS A CONSEQUENCE OF: DIABETIC NEPHROPATHY.					
(C) _____					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Nov 17 1968 to Nov 22 1968, that (1) (we) last saw the deceased alive on Nov 22 1968 and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Matthew Pollack M.D.				23B. DATE SIGNED Nov 22 1968	
23C. PHYSICIAN'S NAME (Type) MATTHEW POLLACK, M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/26/68		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland		25A. DATE RECEIVED BY HEALTH DEPT. NOV 26 1968			
25B. NAME OF REGISTRAR Phyllis E. Jenkins		25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.		25D. ADDRESS	

DIABETIC NEPHROPATHY

URICEMIA

Walter F. Jones M.D.

Nov 25 1958

8

Nov 25 1958

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11799 CERTIFICATE OF DEATH

REG. NO. 68-11799

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Albert Dyson		11-21-68 9:45 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 59 Provident Hospital, Inc.				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3306 Virginia Avenue	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 4-29-87	9. AGE (In years last birthday) 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Maryland, Charles Co.	
13. FATHER'S NAME William Dyson		14. MOTHER'S MAIDEN NAME Myrtle Brooks		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-5242		17. INFORMANT Mr. Walter Dyson-Son	
				ADDRESS 3306 Virginia Ave.	
18. 436.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebro Vascular Accident DUE TO, OR AS A CONSEQUENCE OF: (B) Partial Gallbladder Obstruction DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertension	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 9, 1968 to November 21, 1968, that (I) (we) last saw the deceased alive on November 21, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Narciso De Borja				23B. DATE SIGNED 11-22-68	
23C. PHYSICIAN'S NAME (Type) Narciso De Borja MD				23D. ADDRESS 1514 Division Street Balto., Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/25/68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.	

Confidential
Part of ~~document~~ document
is ~~confidential~~

From ~~the~~ the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11800
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Katie Boston Miller		2. DATE AND HOUR OF DEATH Nov. 16, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY 19-01		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1321 Edmondson Ave.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1321 Edsonsdson Ave,		
5. SEX Female	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/23/1881	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Moses K. Boston		
14. MOTHER'S MAIDEN NAME Almira Gillis			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Miss Almira Miller- 1321 Edmondson Ave.		
18. 471X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 480X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Influenza DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One week 6 weeks
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 10 1968 to Nov 17 1968 , that (I) (we) lost saw the deceased alive on Nov 17 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William H. Watts			23B. DATE SIGNED 11-22-68		23C. PHYSICIAN'S NAME (Type) William H. Watts
23D. ADDRESS 5314 Arlington Ave Baltimore			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 12/23/68			24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		
24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland			25A. DATE RECEIVED Nov 25 1968		
25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave,		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11801

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11801

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lena A. Walker

2. DATE AND HOUR OF DEATH

Nov. 13, 1968

4 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00

573 Presstman Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

573 PRESSTMAN ST.

5. SEX

Female

6. RACE

Colored

7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ SEPARATED ☐ DIVORCED ☐

8. DATE OF BIRTH

Jan 3, 1899

9. AGE (In years
last birthday)

69

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maid

10B. KIND OF BUSINESS OR INDUSTRY

Revolon-Beauty Salon

11. BIRTHPLACE (State or foreign country)

Washington D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Augustus Fields

14. MOTHER'S MAIDEN NAME

Eliza Alexander

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

118-14-8797

17. INFORMANT

ADDRESS

Mabel Fields-573 Presstman Street

18.

410.0 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Coronary Occlusion

(Immediate)

(B) Coronary Artery Disease (Atherosclerosis) Malignant Hypertension

DUE TO, OR AS A CONSEQUENCE OF:

(C) Generalized Arteriosclerosis

Typ

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Chronic Nephritis and Epilepsy disguised

19A. DATE OF OPERATION

none

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

none

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

no

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

none

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

none

21E. INJURY OCCURRED

While At ☒ home Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

1963 to

Nov 13

1968

that (I) (we) last saw the deceased alive on

Aug

1968

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Ralph J. Young M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

Nov 15 1968

23C. PHYSICIAN'S
NAME (Type)

Ralph J. Young M.D.

23D. ADDRESS

1532 E Monument St Balto MD

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/18/68

24C. NAME of CEMETERY or CREMATORY

Mount Auburn Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 25 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Herbert E. Nutter-3035 W. North Ave.

ADDRESS

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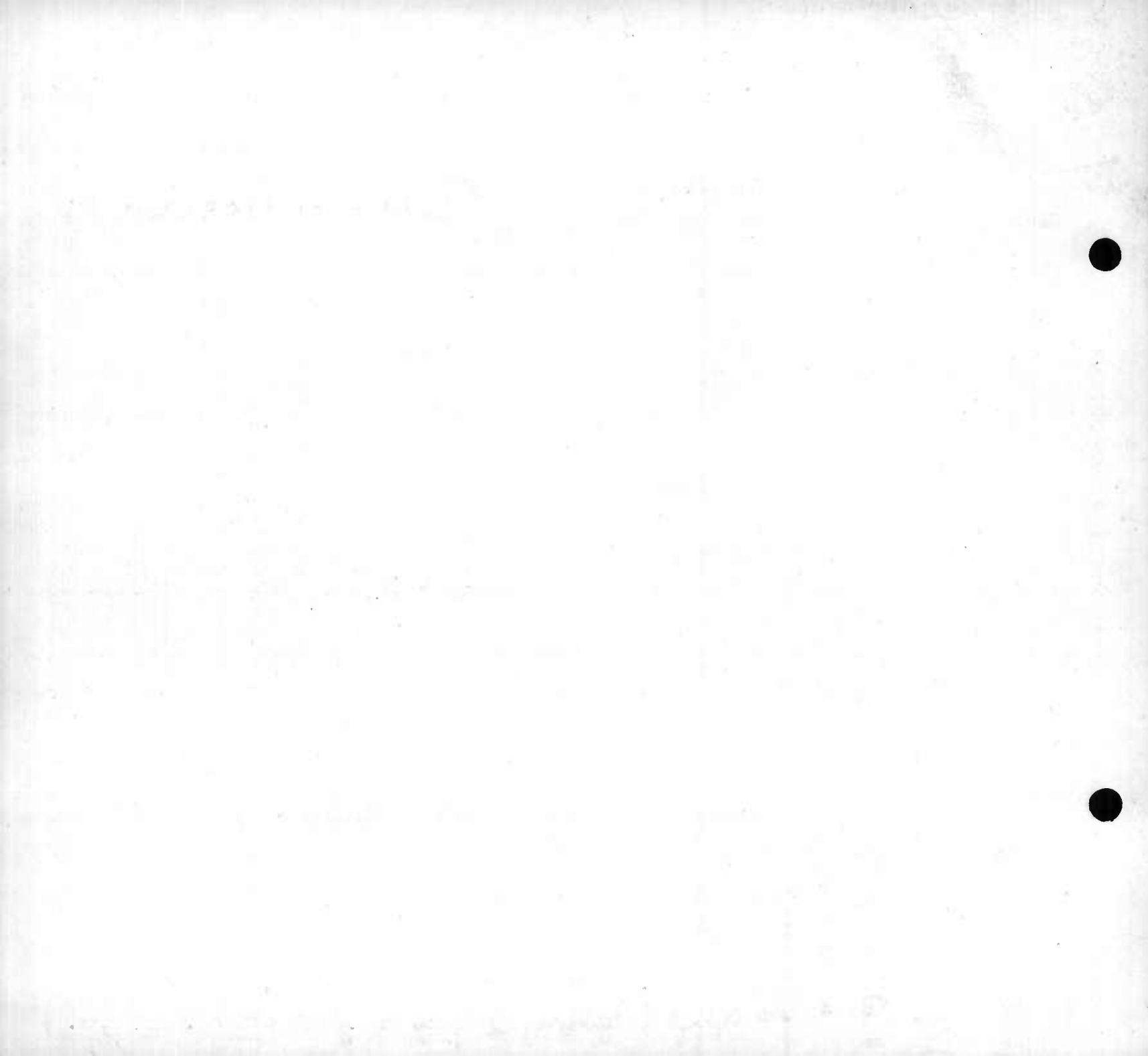
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11802 CERTIFICATE OF DEATH

REG. NO. 68-11802

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES H. PURDY		2. DATE AND HOUR OF DEATH Nov. 23, 1968 6:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2310 MONTICELLO RD.		
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-10-01	9. AGE (In years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN		10B. KIND OF BUSINESS OR INDUSTRY Clothes Retail Shop		11. BIRTHPLACE (State or foreign country) Wilmington, North Carolina	
13. FATHER'S NAME James Purdy			14. MOTHER'S MAIDEN NAME Minnie ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO.		17. INFORMANT GARY LATTIN	
18. 202.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 202.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: POLMONARY edema		30 minutes	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Lymphoblastic Lymphoma & Leukemia		6 years	
		(C) WITH pulmonary infiltrate			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-8 19 68 to 11-23 19 68 , that (I) (we) last saw the deceased alive on 11-23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gary Lattin				23B. DATE SIGNED 11-23-68	
23C. PHYSICIAN'S NAME (Type) GARY LATTIN				23D. ADDRESS University of Maryland Hosp. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE RECEIVED BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Herbert E. Nutter	
				ADDRESS 3035 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11803 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-11803

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HESS, NELLIE B.		2. DATE AND HOUR OF DEATH 11-24-68, 4:25 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 28-02	
FULL NAME OF HOSPITAL OR INSTITUTION 36 FRANKLIN SQUARE HOSPITAL 100 N. CALHOUN ST BALTIMORE, MARYLAND		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9/30/93 9. AGE (In years last birthday) 75	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Elmer Hess	
14. MOTHER'S MAIDEN NAME Lydia Nail		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-03-1047	
17. INFORMANT Carroll Hess-211 E. Baltimore Street		ADDRESS Taneytown, Maryland 21787		18. CAUSE OF DEATH 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CARCINOMATOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PRIMARY BREAST CA. (L) 170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-22-68 to 11-24-68 , that (I) (we) last saw the deceased alive on 11-24-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) PABLO R. BARROLO MD				23D. ADDRESS FRANKLIN SQUARE HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-27-68		24C. NAME OF CEMETERY or CREMATORY Trinity Luth Church Cemetery	
24D. LOCATION (City, town, or county) Taneytown, Maryland		24E. NAME OF REGISTRAR Robert E. [Signature]		24F. FUNERAL DIRECTOR Ellsworth Armacost-4600 Liberty Hgts.	

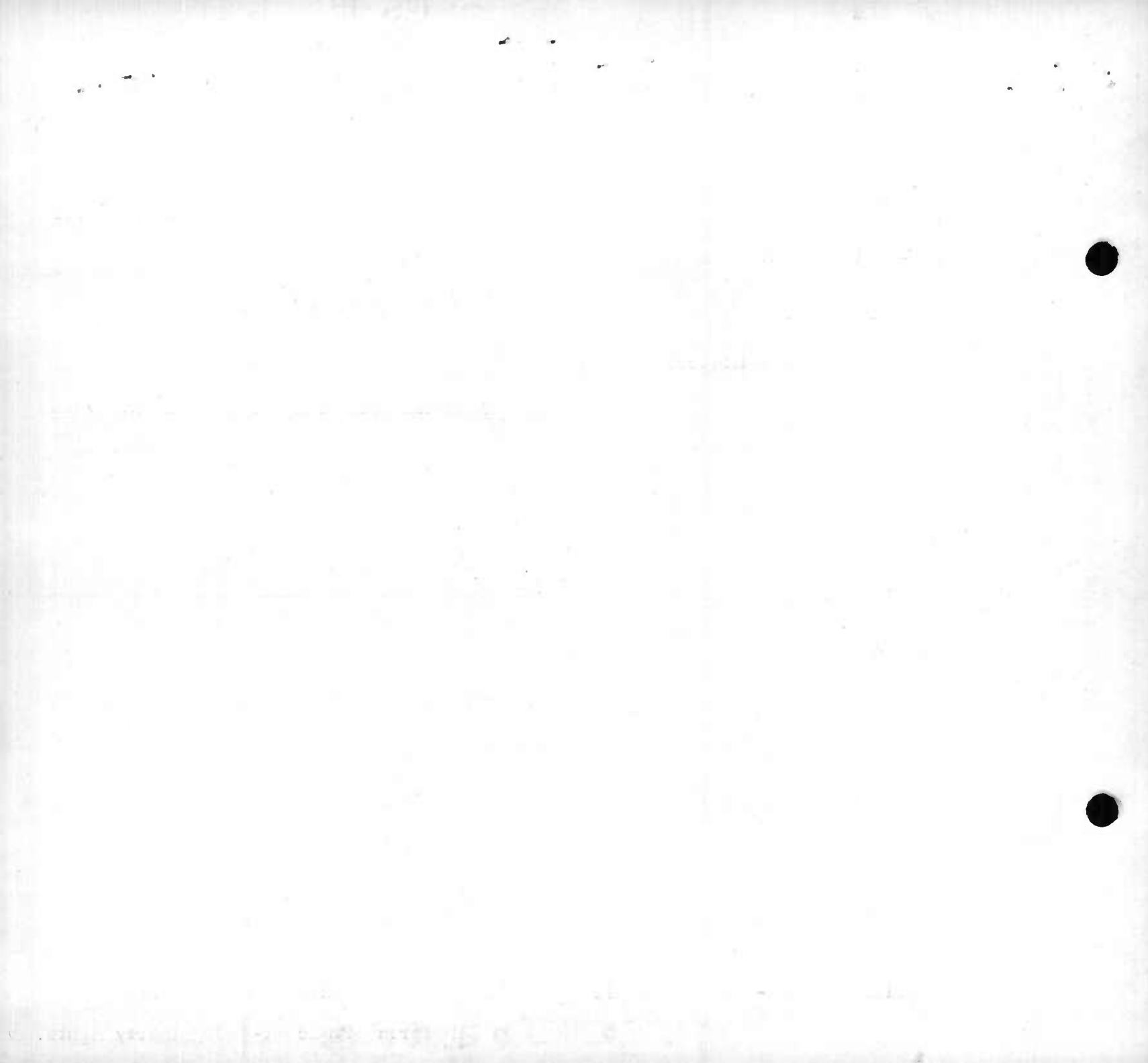
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11804 CERTIFICATE OF DEATH

REG. NO. 68-11804

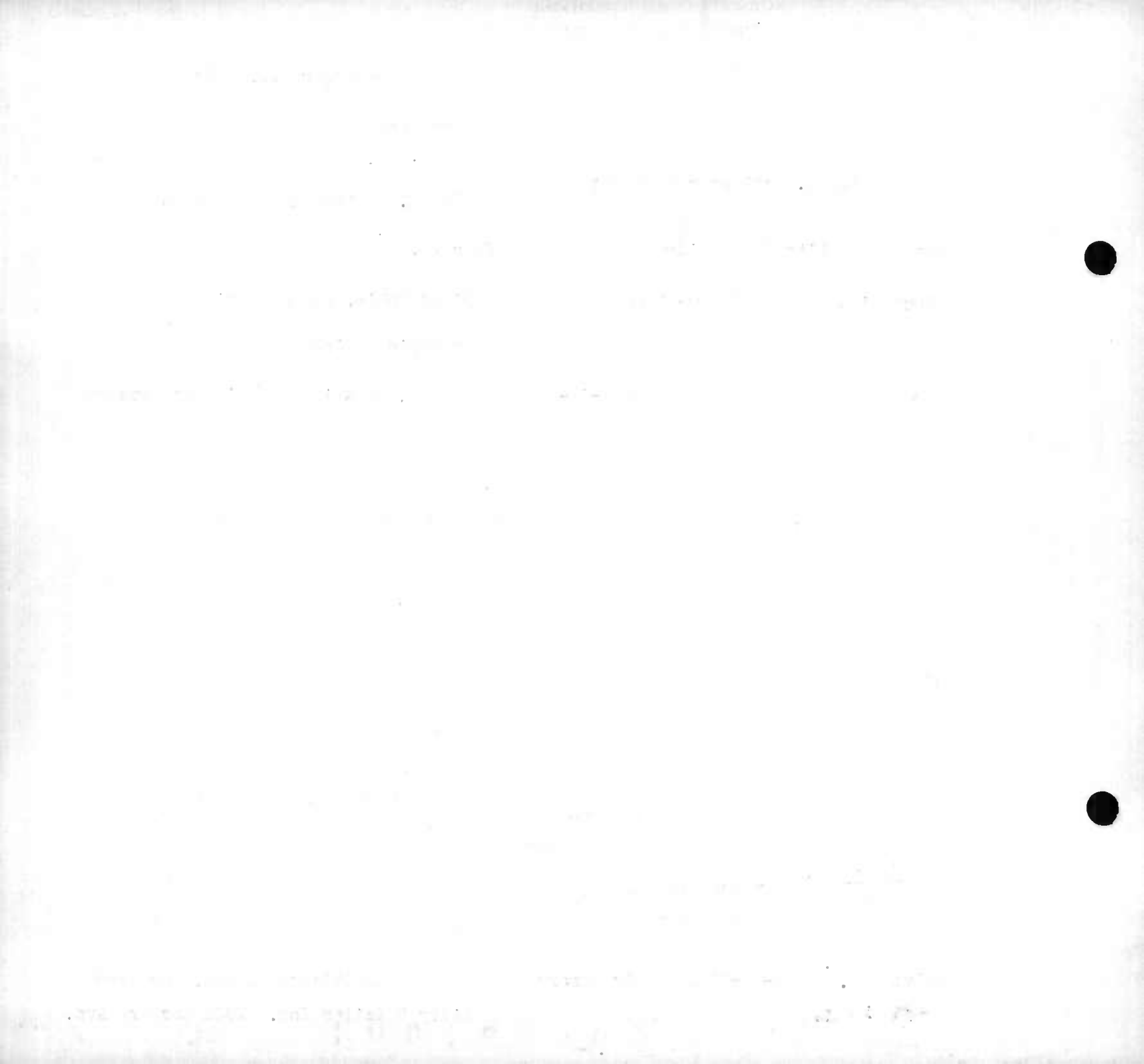
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ETTA V. GRIMSTEAD		2. DATE AND HOUR OF DEATH Nov. 22, 68 2:15 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSP			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Balt C. CITY OR TOWN Balt D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3523 Oakmont Avenue 21215		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/3/09	9. AGE (In years last birthday) 59
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Mittnacht			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT Zerrlaut
			ADDRESS Monetta Grimstead-3523 Oakmont Avenue		
18. 3-99-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal insuff. → CHF (B) G.U. infection up to story for DUE TO, OR AS A CONSEQUENCE OF: 5 years Cardiac any other (C) 3 hrs.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11-9-68 → 11-22-68 10-29-68 → 11-22-68	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 609X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/29 19 68 to 11-22 19 68 , that (I) (we) last saw the deceased alive on Nov. 22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Victor Casada M.D.				23B. DATE SIGNED 11-22-68 2:15 PM	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-25-68		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
		24D. LOCATION (City, town, or county) Baltimore Maryland		(State)	
25A. DATE RECEIVED BY HEALTH DEPARTMENT NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Ellsworth Admacost-4600 Liberty Hghts. Av	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BALTIMORE CITY HEALTH DEPARTMENT</p>		<p>CERTIFICATE OF DEATH</p>		<p>Registered No. _____</p>	
<p>BIRTH NO. D-520</p>		<p>68-11805</p>		<p>68-11805</p>	
<p>M.E. CASE NO. _____</p>		<p>1. NAME OF DECEASED (Type or Print) MARY DEMSKI</p>		<p>2. DATE AND HOUR OF DEATH November 22, 1968</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____</p>			
<p>FULL NAME OF HOSPITAL OR INSTITUTION 326 S. Patterson Park Avenue</p>		<p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p>			
<p>D. STREET ADDRESS (If rural, give location) 326 S. Patterson Park Avenue</p>		<p>E. _____</p>			
<p>5. SEX Female</p>	<p>6. RACE White</p>	<p>7. MARRIED, NEVER MARRIED Widowed, DIVORCED (specify)</p>	<p>8. DATE OF BIRTH July 16, 1903</p>	<p>9. AGE (In years last birthday) 65</p>	<p>If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Own Home</p>		<p>11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania</p>	
<p>12. CITIZEN OF WHAT COUNTRY? _____</p>		<p>13. FATHER'S NAME _____</p>			
<p>14. MOTHER'S MAIDEN NAME Catherine Glinka</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>			
<p>16. SOCIAL SECURITY NO. 217-09-4643</p>		<p>17. INFORMANT ADDRESS Andrew J. Demski 7835 Hillsway Avenue</p>			
<p>18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CORONARY THROMBOSIS DUE TO ARTERIOSCLEROTIC HYPERT. (B) CARDIO-VASC. DISEASE DUE TO (C) _____</p>		<p>INTERVAL BETWEEN ONSET AND DEATH _____</p>			
<p>19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>		<p>19A. DATE OF OPERATION _____</p>			
<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____</p>		<p>20A. AUTOPSY? (Yes or No) _____</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? _____</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from May 1963 to Nov. 22 1968, that (I) (we) last saw the deceased alive on Nov 8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE A. Lemischka</p>		<p>M.D. _____ Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>		<p>23B. DATE SIGNED Nov 25-68</p>	
<p>23C. PHYSICIAN'S NAME (Type) A. LEMISCHKA</p>		<p>23D. ADDRESS 2608 E. BALTIMORE ST. BALTO.</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>	<p>24B. DATE 11-26-1968</p>	<p>24C. NAME of CEMETERY or CREMATORY Holy Rosary</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. NOV 24 1968</p>		<p>25B. NAME OF REGISTRAR Robert E. [unclear]</p>		<p>25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. **68-11806**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SCHMIDT, HENRY HERMAN		2. DATE AND HOUR OF DEATH NOVEMBER 23 '68 5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY U.S.A.		
FULL NAME OF HOSPITAL OR INSTITUTION 36 FRANKLIN SQUARE HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2801 E. Northern Pkwy.		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/10/00	9. AGE (In years lost birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME HENRY SCHMIDT		
14. MOTHER'S MAIDEN NAME CAROLINE LOTZ			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		
16. SOCIAL SECURITY NO. 219-22-0148			17. INFORMANT HILDA SMITH		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 441.0 I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Massive pleural hemorrhage (A) IMMEDIATE CAUSE A.S. C. V. H. D. DUE TO, OR AS A CONSEQUENCE OF: Ruptured dissecting aneurysm (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 451X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Acute Heart Attack		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) —	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 11-20 1968 to 11-23 1968 , that (I) (we) lost saw the deceased alive on 11-23 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Vanasin				23B. DATE SIGNED 11-23-68	
23C. PHYSICIAN'S NAME (Type) C. VANASIN				23D. ADDRESS Franklin Square Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/21/68		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balt. Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

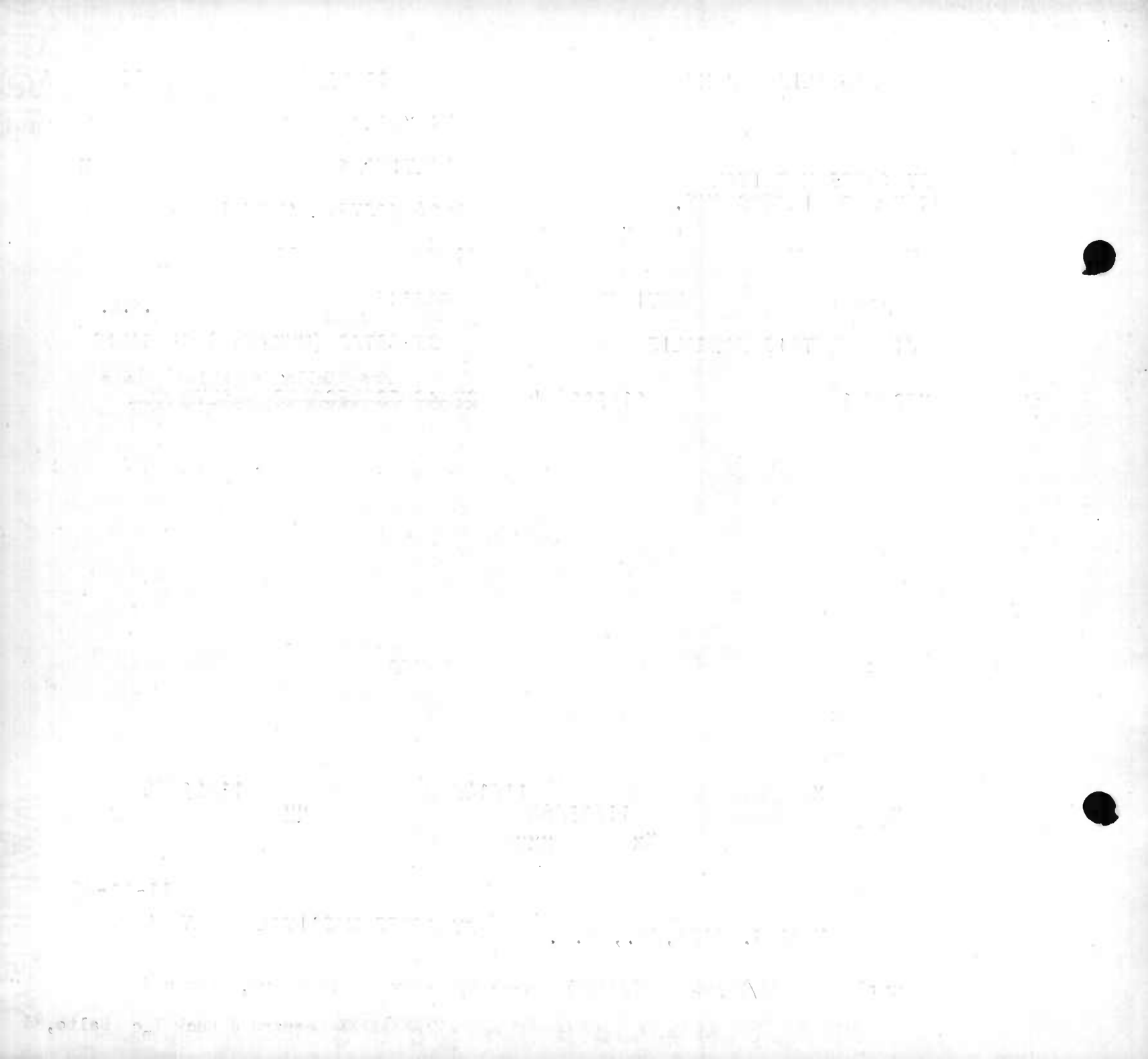
68-11807

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11807

BIRTH NO.		1. NAME OF DECEASED (Type or Print) PANGALIS JOHN D		2. DATE AND HOUR OF DEATH 11/23/68 11 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto Co. 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL CATON & WILKENS AVE.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 422 1/2 EASTERN AVENUE			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01 06 96	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) GREECE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JIM DEMETRIS PANGALIS		14. MOTHER'S MAIDEN NAME SEVESTAS (UNKNOWN) PANGALIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 219322684		17. INFORMANT Mrs Stella Pangalis ADDRESS Same ST. AGNES RECORDS - BALTO. MD.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction (B) Chronic Brain Synd. DUE TO, OR AS A CONSEQUENCE OF: Chronic Nephroses & Chronic Uremia (C) Chronic Nephroses & Chronic Uremia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-10"	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 11/14/68 19 to 11/23/68 19 that (X) (we) last saw the deceased alive on 11/23/68 19 and that (XX) (our) opinion death occurred on the date and hour and from the causes stated above (XX) (We) (did) (XXX) view the body after death.					
23A. SIGNATURE James G. Kane, Jr., M.D.		23B. DATE SIGNED 11-23-68		23C. PHYSICIAN'S NAME (Type) JAMES G. KANE, JR., M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/26/68		24C. NAME OF CEMETERY or CREMATORY St. Agnes Greek Orthodox	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Leonard J Ruck Inc		25D. ADDRESS Balto, Md			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11808

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Goldia F Leverton GOLDIE COLO LEVERTON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 11 Day 22 Year 68 Estimated <input type="checkbox"/> 3:50 p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month November Day 22 Year 1968 3:50 p M.	
6. SEX Female 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH May 20, 1890 10. AGE (In years last birthday) 78 11. BIRTHPLACE (State or foreign country) Penna		E. STREET AND NUMBER 541 Bayside Dr. Inverness, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Francis F Graham	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Katherine Kirkwood	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-05-0765	
18. INFORMANT Mrs Beatrice Weitzel		ADDRESS 6006 Winthrop Ave	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.47-E 819.1 Arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II Fracture of lumbar spine		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown	
22C. WHERE DID INJURY OCCUR? Unknown		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 10 21 68 ? m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject passenger in auto accident	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N Kornblum M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/26/68	
24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Farley	
		25C. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc Baltimore, Maryland	

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MAY 20 1950

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11809 CERTIFICATE OF DEATH

REG. NO. **68-11809**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Henry E. Fowler</i>		2. DATE AND HOUR OF DEATH <i>11-23-68</i> <i>11:10</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>South Baltimore General Hospital</i> <i>43</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>405 S. Ellwood Ave.</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-28-01</i>	9. AGE (In years last birthday) <i>67</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Ins Agent</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>William Fowler</i>			14. MOTHER'S MAIDEN NAME <i>Sophie Hillgleman</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-09-1011</i>		17. INFORMANT <i>Mrs Leeta E Fowler</i> Same	
18. <i>531.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>540.1</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiovascular Collapse</i> (B) <i>Cardiac Arrest & Shock</i> (C) <i>Perforated Gastric Ulcer</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>5 days</i> <i>5 days</i>
19A. DATE OF OPERATION <i>3-18-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Perforated Gastric Ulcer</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>None</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>None</i>	
21D. TIME OF INJURY (APPROX.) <i>None</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>None</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>11-18-1968</i> to <i>11-23-1968</i> , that (I) (we) last saw the deceased alive on <i>11-23-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>F. W. Colligan</i>			23B. DATE SIGNED <i>11-23-68</i>		23C. PHYSICIAN'S NAME (Type) <i>F. W. Colligan</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>11/26/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oaklawn</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			25A. DATE REC'D BY HEALTH DEPT. <i>NOV 25 1968</i>		
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR <i>L. D. Luck Inc.</i>		
ADDRESS <i>Baltimore, Md</i>					

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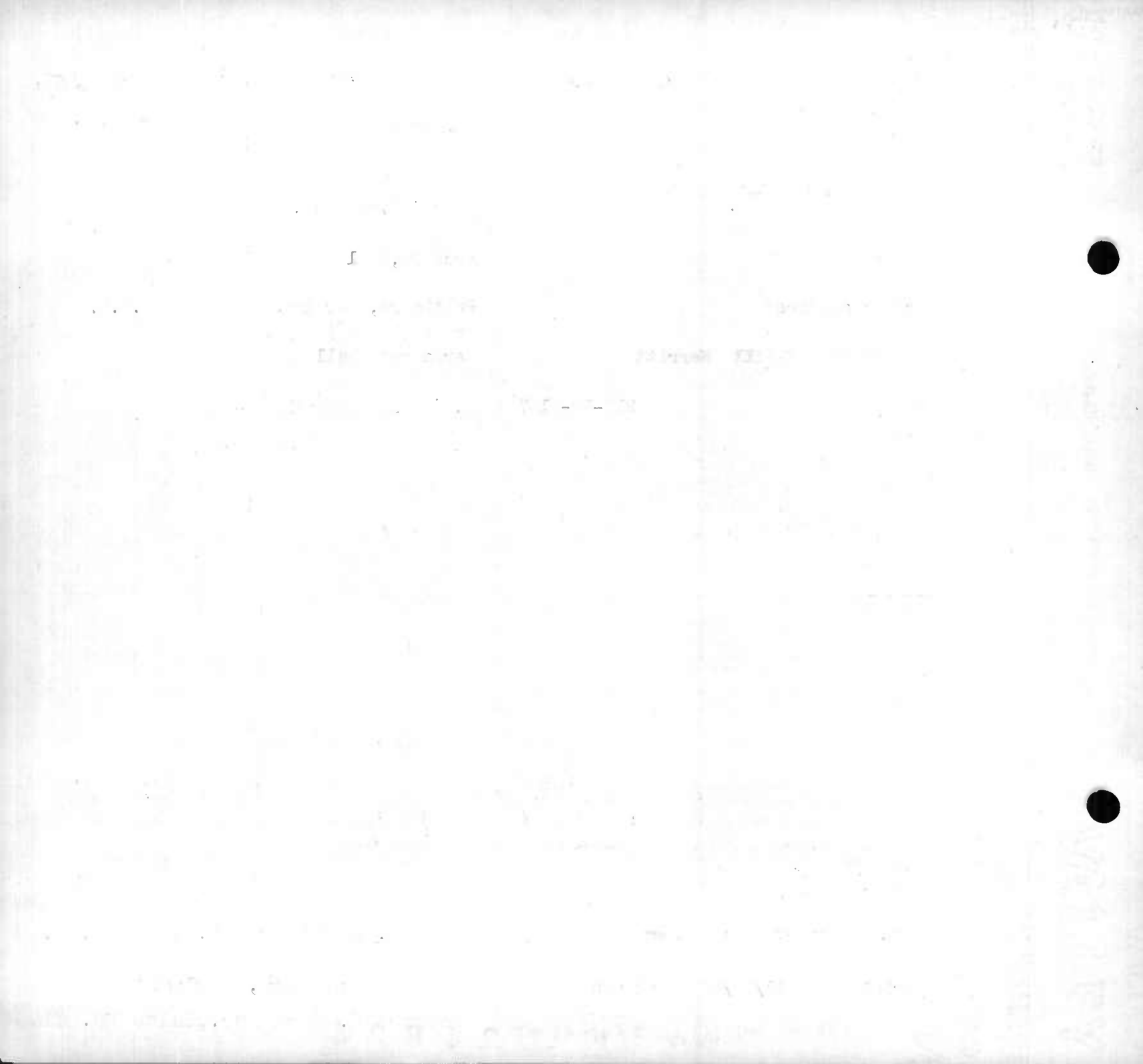
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11810 CERTIFICATE OF DEATH

REG. NO. 68-11810

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ELIZA EMMA MERRITT		November 22, 1968 1:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Nursing Home				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2827 Hudson St.	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1881	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seamstress		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Ethington S. Merritt		14. MOTHER'S MAIDEN NAME Marga ret Bell		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-5187		17. INFORMANT Mrs. Evelyn Merritt-- Same	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arterio sclerotic Heart Dis.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1968 to present 19 that (I) (we) last saw the deceased alive on Nov 20 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles E. MacMinn				23B. DATE SIGNED Nov 22 1968	
23C. PHYSICIAN'S NAME (Type) Dr. Charles MacMinn				23D. ADDRESS 2900 E. Baltimore St., Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/25/68		24C. NAME OF CEMETERY or CREMATORY Oaklawn	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc., Balto Md. #14		25D. ADDRESS		25E. DATE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11811				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11811	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MURPHY, IRENE		2. DATE AND HOUR OF DEATH 12 15 PM 11/22/68			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Md. General Hosp. Hl				A. STATE Md. B. COUNTY Baltimore			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore, Md.		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
				E. STREET AND NUMBER 304 Regester Avenue			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-11-15	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William F. Morwood				14. MOTHER'S MAIDEN NAME Susie Ely			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-03-8045		17. INFORMANT Hosp. Identi. Record	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 191X I				CAUSE OF DEATH Glioblastoma multiforme		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 193.0 II							
19A. DATE OF OPERATION 11-8-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain tumor		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-1-68 19 to 11-22 19 68 , that (I) (we) last saw the deceased alive on 11/22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Marvin C. Sachs, M.D.				23B. DATE SIGNED 11-22-68		23C. PHYSICIAN'S NAME (Type) MARVIN C. SACHS, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/25/68		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto. Md. 21214	

Mr. General Wright

F W

X

3-11-12 23

for Mr. W.

William F. Morrison

Gloucester with forms

West Hill from front

11/12

11-1-12

Mrs. C. Morrison

M. L. Gen. Wright

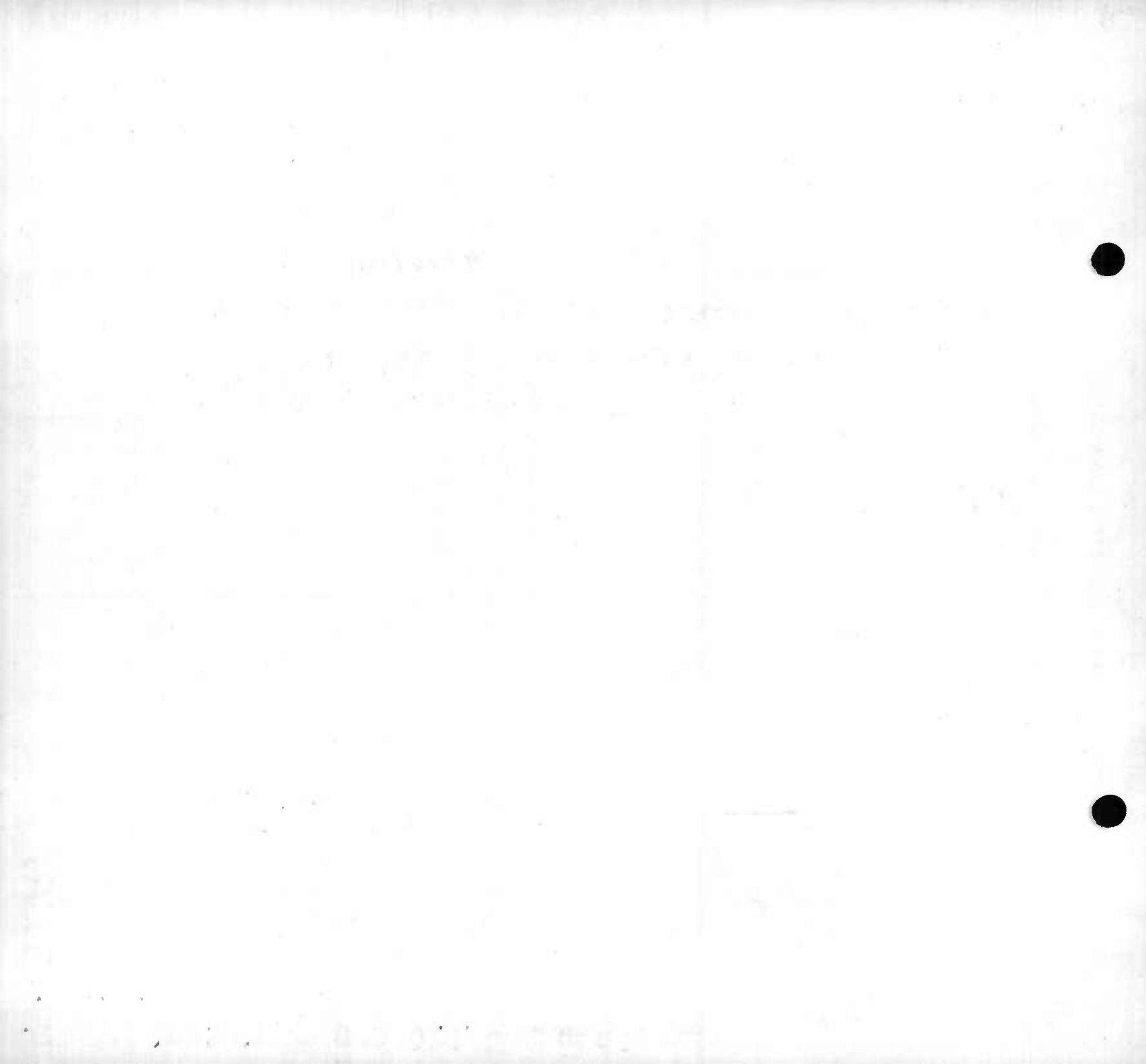
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11812 CERTIFICATE OF DEATH

REG. NO. 68-11812

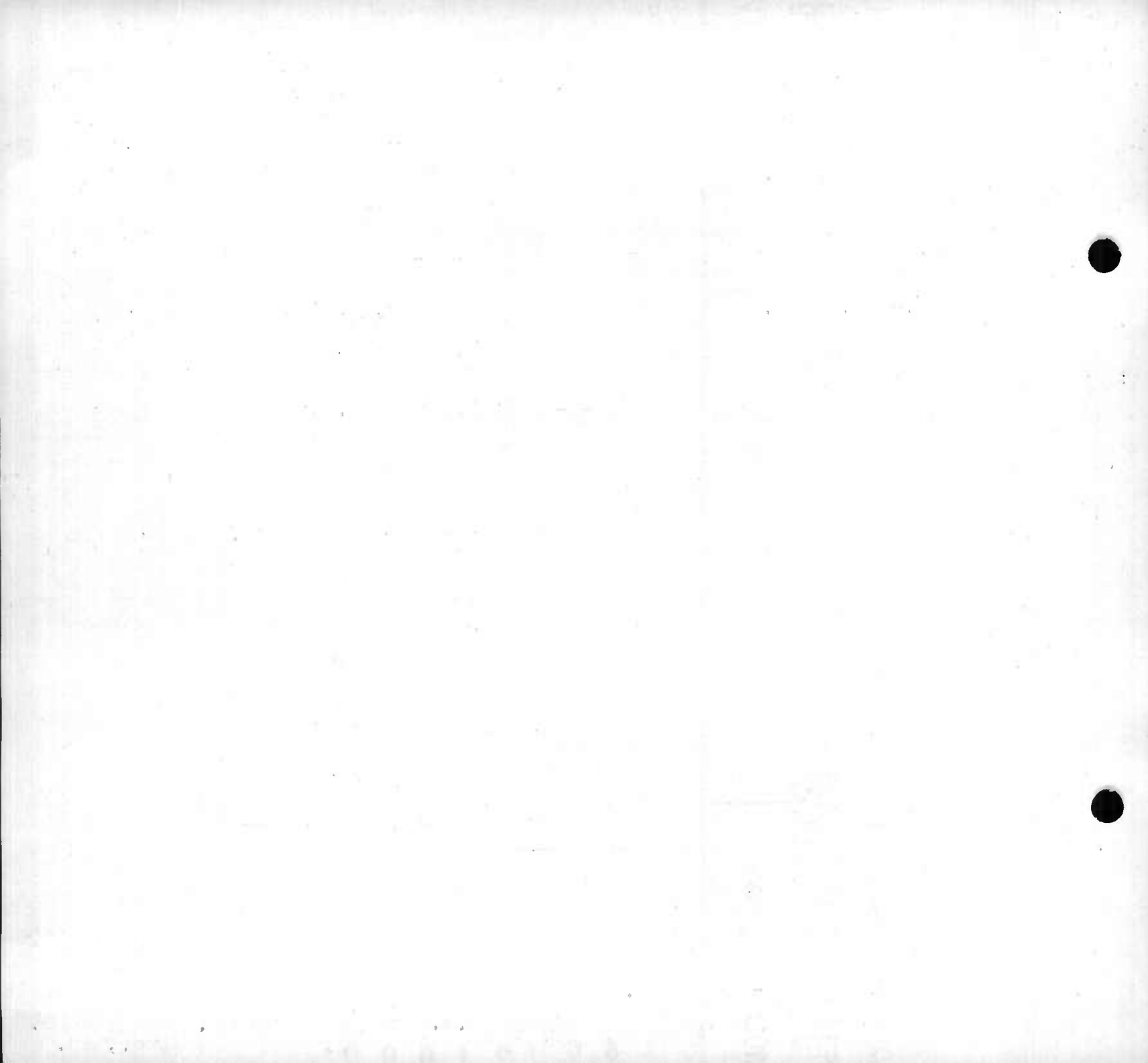
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MARY L. MORGAN</u>		2. DATE AND HOUR OF DEATH <u>11/21/68 - 6 pm</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS HOSPITAL</u> <u>34</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>201 N. ROLLING ROAD</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/16/1890</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED BOOKKEEPER CLOTHING</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FREDERICK W. LENHARD</u>		14. MOTHER'S MAIDEN NAME <u>MARY PREUTT</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-5975</u>		17. INFORMANT <u>DR. RAYMOND E. LENHARD</u>	
18. <u>481X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardio-respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>RS lower lobe pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11-21-68</u>	
19. <u>490X</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-19</u> 19 <u>68</u> to <u>11-21</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-21</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>11-22-1968</u>		23C. PHYSICIAN'S NAME (Type) <u>JOHNNY T. YAP MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/25/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge</u>	
24D. LOCATION <u>Pikesville, Balto. Co., Md.</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>NOV 25 1968</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>	
25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		25D. ADDRESS <u>1905 York Rd. Balto. 12, Md.</u>		25E. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11813
BIRTH NO. 1. NAME OF DECEASED (Type or Print) MARGARET MARY McMULLEN		2. DATE AND HOUR OF DEATH Nov. 22, 1968 6 15 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 5216 Tilbury Way		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore 5216 Tilbury Way C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-21-1892	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Tel. Oper.		10B. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Chicago, Illinois	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Daniel Broderick			
14. MOTHER'S MAIDEN NAME Ellen O'Donnell		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 22-44-3935		17. INFORMANT Margaret J. Barnes			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I CORONARY THROMBOSIS 1 MINUTE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 YRS			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II GENERALIZED ARTERIOSCLEROSIS ?		20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC HEART DISEASE			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 1955 to Nov 22 1968 , that (I) (we) last saw the deceased alive on Nov 20 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE John M. Scott M.D.		23B. DATE SIGNED Nov. 22, 1968		23C. PHYSICIAN'S NAME (Type) JOHN M. SCOTT	
23D. ADDRESS 600 W. BELVEDERE AVE BALTIMORE, 21210 MARYLAND		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11-26-68		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel		24D. LOCATION (City, town, or county) (State) Hillside Illinois	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
25D. ADDRESS 4905 York Rd. Balto., Md.		VS 150-REV. 1/1/68			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11814
BIRTH NO. 68-11814		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) EVA McPHERSON		2. DATE AND HOUR OF DEATH 23 Nov. 68 7:45 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION MERCY Hospital		A. STATE MARYLAND B. COUNTY BALTIMORE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALT. MORE Md.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
37		E. STREET AND NUMBER 3809 Hadley Avenue East		
5. SEX FEMALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/89	9. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired TEACHER EDUCATION		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME DAVID LYON McPHERSON		14. MOTHER'S MAIDEN NAME EVARISTA Hooper		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-40-1357		17. INFORMANT MISS HELEN McPHERSON (SAME ADDRESS)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PULMONARY EMBOLISM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD, Diabetes Mellitus		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSION		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) PSEUDOCYST OF PANCREAS		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 5-87-2 II				
19A. DATE OF OPERATION 13 Nov. 68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CYST OF PANCREAS		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 10/29/68 to 23 Nov. 1968 , that (I) (we) lost saw the deceased alive on Nov. 23 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Dale P. Baker MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 23 Nov. 68
23C. PHYSICIAN'S NAME (Type) DALE P. BAKER		23D. ADDRESS MERCY Hospital, BALTIMORE Md.		
24A. BURIAL CREMATION REMOVAL (Specify) Burial	24B. DATE 11/27/68	24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11815

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11815

BIRTH NO.		1. NAME OF DECEASED (Type or Print) (Francis P.) Mr. Frank J. Gavin		2. DATE AND HOUR OF DEATH 11-22-1968 10-50 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 12-06		
FULL NAME OF HOSPITAL OR INSTITUTION 00 2508 N. Charles Street Baltimore, Maryland 21218			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male			6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10B. KIND OF BUSINESS OR INDUSTRY Crown-Cork & Seal		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Gavin			14. MOTHER'S MAIDEN NAME Alice Dunn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-8515		17. INFORMANT Saile F. Gavin ADDRESS Balto. 3219 N. Calvert St.	
18. 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 450.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) arthritis of the thoracic spine, curvature of the throacic spine.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 11-11-1968		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-18- 19 63 to 11-8 19 68 , that (I) (we) last saw the deceased alive on 11-8- 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook				23B. DATE SIGNED 11-22-68	
23C. PHYSICIAN'S NAME (Type) Elmer Ellsworth Cook, M.D.				23D. ADDRESS 2431 Maryland Avenue, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-25-68		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial Timonium Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 25 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Balto., Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11816 CERTIFICATE OF DEATH

REG. NO.

68-11816

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ada B. Mahool

2. DATE AND HOUR OF DEATH

Nov. 24, 1968

7:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

21 Merrymount Road

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore 21210

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

21 Merrymount Road

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

10/2/1873

9. AGE (In years last birthday)

95

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Bowerman

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-09-0392 Thomas Mahool, Jr.

17. INFORMANT ADDRESS

(Same)

18.

440.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1960 to Nov 24 1968, that (I) (we) last saw the deceased alive on Nov 22 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

11-25-68

23C. PHYSICIAN'S NAME (Type)

Dr. William G. Helfrich

23D. ADDRESS

5006 Roland Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/26/68

24C. NAME OF CEMETERY or CREMATORY

Druid Ridge Cem.

24D. LOCATION

(City, town, or county)

(State)

Pikesville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR ADDRESS

H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11817 BALTIMORE CITY HEALTH DEPARTMENT
REG. NO. 68-11817

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WASHINGTON, Robert A.		2. DATE AND HOUR OF DEATH 11/21/68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 7-05		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1600 Millman Street		5. SEX Male		6. RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/12/24		9. AGE (In years lost birthday) 44	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand		10B. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Jamestown, S.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alex Washington		14. MOTHER'S MAIDEN NAME Florence Myers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9/24/43 - 1/13/46		16. SOCIAL SECURITY NO. 249-30-2854		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma of the lung		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
165X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Oct 24th 19 68 to Nov 21st 19 68 , that (1) (we) last saw the deceased alive on Nov 21st 19 68 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marvin Mengel M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED November 21, 1968	
23C. PHYSICIAN'S NAME (Type) MARVIN MENGEL, M.D.		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 11/27/68		24C. NAME OF CEMETERY or CREMATORY South C. Calver	
24D. LOCATION South C. Calver		24E. CITY, TOWN, OR COUNTY South C. Calver		24F. STATE South C. Calver	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Pauling K. Canale	

John - Charles

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11818 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-11818

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mrs. Minnie Helwig		2. DATE AND HOUR OF DEATH Nov. 23, 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital Caton & Wilkens Aves. Baltimore, Md. 21229				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (Arbutus) Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5505 Heatherwood Road (21227)			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/12/07	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembly Line		10B. KIND OF BUSINESS OR INDUSTRY Calvert Distillery Baltimore		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (late) William Stoker				14. MOTHER'S MAIDEN NAME Gertrude (late)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-05-3693		17. INFORMANT ADDRESS Mr. Charles Helwig-5505 Heatherwood Rd.			
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Coronary Thrombosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardio Vascular Renal Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 da 5 yrs			
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/10/63 19 to 11/23 19 68 , that (I) (we) lost saw the deceased alive on 11/23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph G. Laukaitis MD				23B. DATE SIGNED 11/26/68		23C. PHYSICIAN'S NAME (Type) Dr. Joseph G. Laukaitis	
23D. ADDRESS 679 Washington Blvd., Balto., Md.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11/27/68				24C. NAME OF CEMETERY or CREMATORY Baltimore Natl. Cemetery Baltimore, Maryland		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968				25B. NAME OF REGISTRAR Robert E. Sullivan		25C. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Avenue	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11819 CERTIFICATE OF DEATH

REG. NO. 68-11819

BIRTH NO.		1. NAME OF DECEASED (Type or Print) PETERS, MABEL		2. DATE AND HOUR OF DEATH NOVEMBER 24, 1968 12:50P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES ; HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY Howard Co 63-00 C. CITY OR TOWN SIMPSONSVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 210 SENECA DR 52110		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06/16/95	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Sales Clerk Hecht Co.		11. BIRTHPLACE (State or foreign country) GEORGIA	
13. FATHER'S NAME WALKER			14. MOTHER'S MAIDEN NAME MABEL WALKER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 220-38-9221		17. INFORMANT ST. AGNES HOSPITAL RECORDS	
18. CAUSE OF DEATH					
I 571.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Bleeding esophageal varices DUE TO, OR AS A CONSEQUENCE OF: hypertension (B) Atherosclerosis, probably Raemmer's DUE TO, OR AS A CONSEQUENCE OF: (C)		
MEDICAL CERTIFICATION					
II 581.1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 15 1968 to NOVEMBER 24 1968 , that (I) (we) last saw the deceased alive on NOVEMBER 24 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles J. Lancelotta MD				23B. DATE SIGNED 11/24/68	
23C. PHYSICIAN'S NAME (Type) CHARLES J LANCELOTTA MD				23D. ADDRESS BALTO, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/68		24C. NAME OF CEMETERY or CREMATORY Harmony Presbyterian	
24D. LOCATION Glenville, Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 26 1968			
25A. NAME OF REGISTRAR Robert E. Tuley		25B. NAME OF REGISTRAR Howard Co. Funeral Home of Harry H. Witzke		25C. FUNERAL DIRECTOR Ellis C. Elliott City, Md	

Received of the
Hon. Secy of the Navy
the sum of \$100.00
for the purchase of
the sum of \$100.00

For the purchase of
the sum of \$100.00

1
G-652

68-11820 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11820

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HARRY GROOMS (HARRY W. GROOMS, SR.)

2. DATE
OF DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

11

20

1968

6:25 a. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

Lutheran Hospital D.O.A.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 20, 1968 6:25a M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Male

Colored

Balto.

YES ☒NO ☐

9. DATE OF BIRTH

6-15-1888

10. AGE (In years
last birthday) 80If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3311 Winterbourne Road

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas Grooms

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Custodian

14B. KIND OF BUSINESS OR INDUSTRY

J.H. University

15. MOTHER'S MAIDEN NAME

Maggie

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.
215-05-7139

18. INFORMANT

ADDRESS

Alma Weems - 3311 Winterbourne Road

19. E814.7 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Injuries
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

E812.4 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Road

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Hilton Parkway S. of North Ave.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) 11 20 1968 6:10a m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-25-68

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county)

Baltimore, Maryland

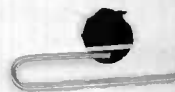
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Charles R. Law 802 Madison Ave.



5.412



This certificate must be approved by the chief medical examiner of his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11821 CERTIFICATE OF DEATH

REG. NO.

68-11821

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Alice E. Lindsey

2. DATE AND HOUR OF DEATH

11-24-68

12 Noon

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)33 THE JOHNS HOPKINS HOSPITAL
BALTIMORE, MD 21205

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1034 BRANTLEY AVE

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

1-9-88

9. AGE (In years
last birthday)

80

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THOMAS ROBINSON

14. MOTHER'S MAIDEN NAME

ELIZABETH BROWN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Frisby Lindsey - 1034 Brantley Ave.

18.

410.0 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Acute Myocardial Infarction

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

at termination of sigmoidoscopy

(B) DUE TO, OR AS A CONSEQUENCE OF:

Acute Sigmoiditis

(C) DUE TO, OR AS A CONSEQUENCE OF:

Hemorrhage of superior mesenteric
artery with bowel infarction.APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

16 hr.

MEDICAL CERTIFICATION

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2 11/23/68

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

ACUTE ABDOMEN

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Johns Hopkins Hospital

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

11 23 68

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☒

21F. HOW DID INJURY OCCUR?

AFTER sigmoidoscopy

22. I certify that (I) (this hospital) attended the deceased from Nov 23 19 68 to Nov 24 19 68,
that (I) (we) lost saw the deceased alive on Nov 24 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Paul Redstone

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11-24-68

23C. PHYSICIAN'S
NAME (Type)

PAUL REDSTONE

M.D.

DEGREE

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION
REMOVAL (Specify)

Burial

24B. DATE

11-27-68

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 26 1968

Robert G. Taylor

Charles R. Law

802 Madison Ave.



B 530

68-11822 BALTIMORE CITY HEALTH DEPARTMENT

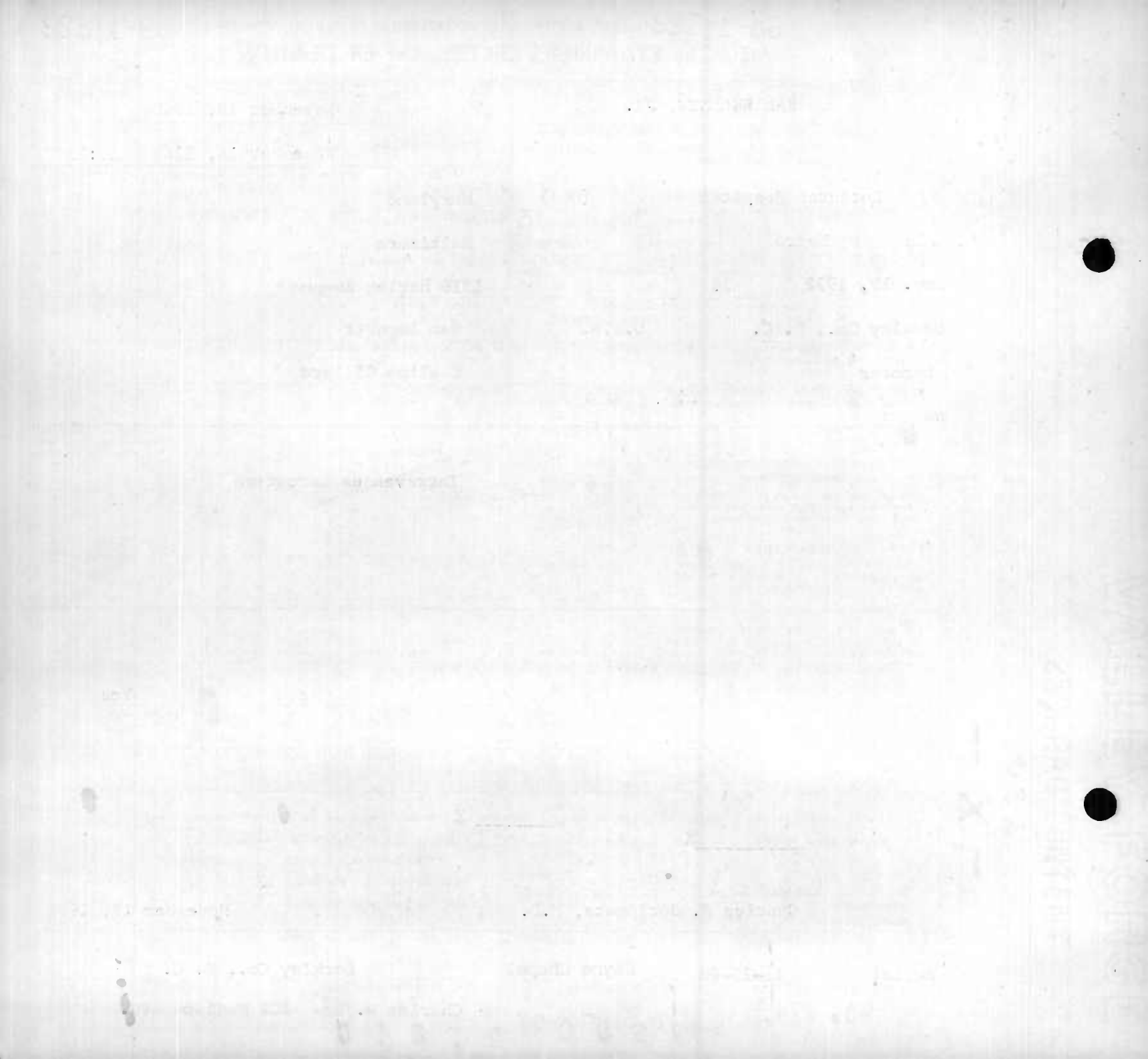
68-11822

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) SAM BENNETT, JR.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 16, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 16, 1968 10:25 P.M.	
6. SEX Male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov. 19, 1932		10. AGE (In years lost birthday) 36 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Berkley Co., S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Evalina Gillard		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 0049 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTRAVENOUS NARCOTISM		CAUSE OF DEATH (A) IMMEDIATE CAUSE Intravenous narcotism DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DATE SIGNED November 17, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-25-68	
24C. NAME OF CEMETERY or CREMATORY Payne Chapel		24D. LOCATION (City, town, or county) (State) Berkley Co., S. C.	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Charles R. Law	
25C. FUNERAL DIRECTOR ADDRESS 802 Madison Ave.			



68-11823

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11823

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS A. SHERMAN

2. DATE AND HOUR OF DEATH

11-20-68 7:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

33 John Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore City

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

415 E. Preston St.

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☒NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

9/29/24

9. AGE (In years
last birthday)

44

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willie Coshy

14. MOTHER'S MAIDEN NAME

Rhea Sherman

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

213-20-3409

17. INFORMANT

ADDRESS

Rhea Sherman - 415 E. Preston St.

18. 199.0 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, oshtenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION lost.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Metastatic Carcinoma

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Q. W. H.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

199.2 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 20 1968 to Nov. 20 1968,
that (I) (we) last saw the deceased alive on Nov. 20 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Paul Redstone

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11-20-68

23C. PHYSICIAN'S
NAME (Type)

Paul Redstone

DEGREE

23D. ADDRESS

John Hopkins Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-26-68

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 26 1968 Robert E. Johnson

Charles R. Law 802 Madison Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

31 50 38
SHERMAN, THOMAS A.

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

Willie Cooty

Rosa Sherman

Male Negro

9/22/24

44

John Hopkins Hospital
415 E. Lexington St.

Baltimore

71st Street

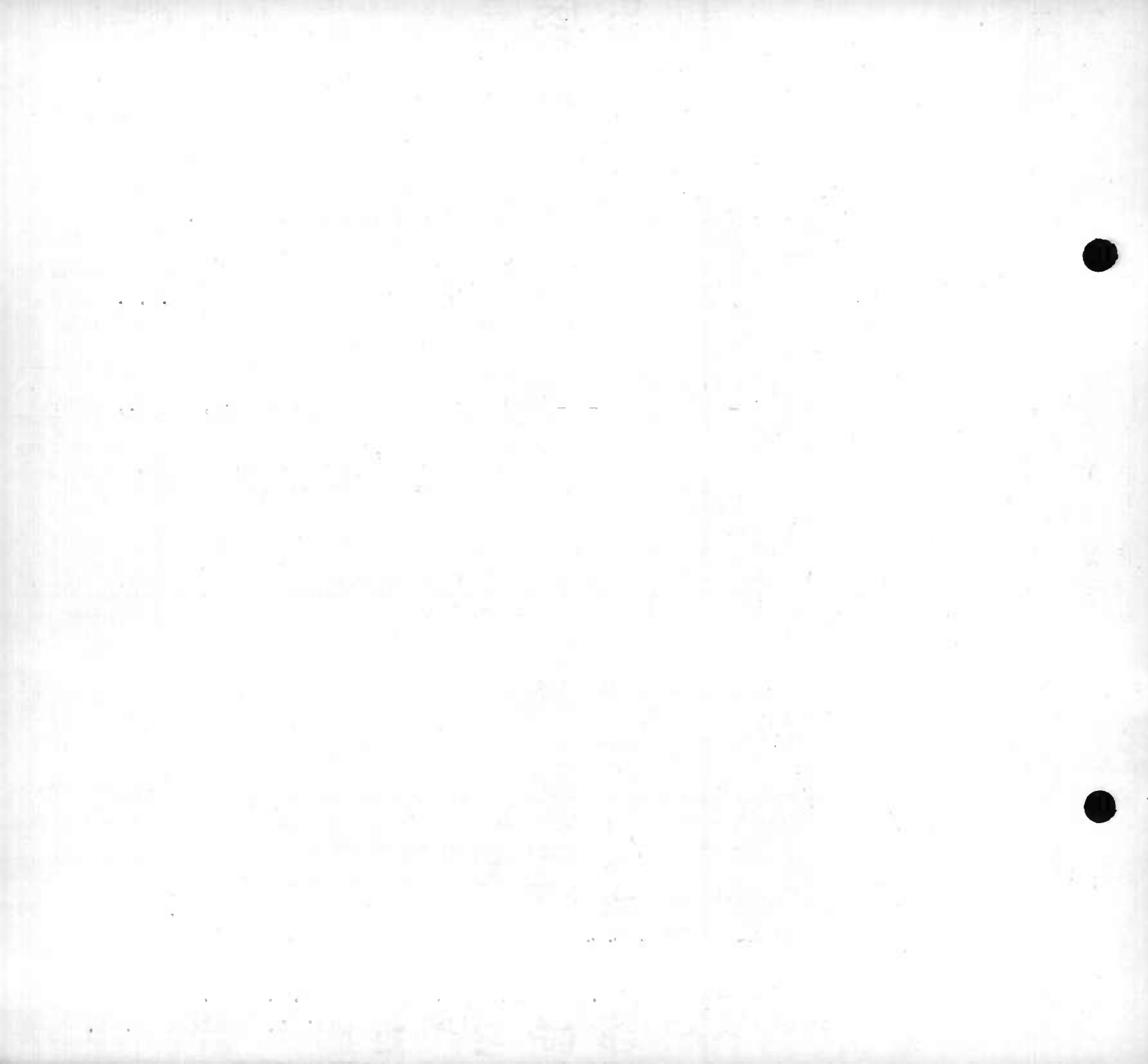
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11824 CERTIFICATE OF DEATH

REG. NO. 68-11824

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SMITH, Roney (NMI)		2. DATE AND HOUR OF DEATH 11/21/68 12:00 NOON	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY 15-01		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4/14/93		9. AGE (In years last birthday) 75		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Smith		14. MOTHER'S MAIDEN NAME Annie Brown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10/13/17 - 7/23/19		16. SOCIAL SECURITY NO. 217-20-3486		17. INFORMANT VA Hospital Records 3900 Loch Raven Boulevard, Balto., Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 207.0 + 1250.9 Leukemia, acute (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 204.3 II Diabetes Mellitus		CAUSE OF DEATH (A) IMMEDIATE CAUSE WITH INFILTRATION OF LUNG AND DUE TO, OR AS A CONSEQUENCE OF: hilar lymph nodes (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH greater than 4 days	
19A. DATE OF OPERATION 11/20/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED bone marrow aspiration to diagnosis leukemia		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from November 16th 19 68 to November 21st 19 68 , that (1) (we) last saw the deceased alive on November 21st 19 68 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George W. Gaffney		23B. DATE SIGNED 11/22/68		23C. PHYSICIAN'S NAME (Type) GEORGE W. GAFFNEY, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-26-68		24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l. Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR V.R. Bailey		25D. ADDRESS 1348 Calhoun St.		25E. ADDRESS Kelson F. H.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11825 CERTIFICATE OF DEATH

REG. NO. 68-11825

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNA E BUEHLER		2. DATE AND HOUR OF DEATH 11/21/68 12⁰⁵ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-04		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Union Memorial Hospital 44			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female		6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/04	9. AGE (In years lost birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES MAGGONNEGALL SIMMS			14. MOTHER'S MAIDEN NAME TILLIE MC GONIGLE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ANNABELLE LEWIS 1606 N. WICK Road Balto Md. 21218	
18. 183.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF: (B) ADENOCARCINOMA (OVARIAN) 18 years DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
175.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 18 19 68 to Nov. 21 19 68 , that (I) (we) last saw the deceased alive on Nov. 21 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ricardo Mori M.D. DEGREE				23B. DATE SIGNED 11-21-68	
23C. PHYSICIAN'S NAME (Type) RICARDO MORI M.D. DEGREE				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/25/68		24C. NAME OF CEMETERY or CREMATORY PARK WOOD CEMETERY	
24D. LOCATION (City, town, or county) (State) PARKVILLE MD		25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968			
25B. NAME OF REGISTRAR Debbie G. [illegible]		25C. FUNERAL DIRECTOR ADDRESS 2 ULLORIA FUNERAL HOME 1720 BELAIR			

Charles H. Johnson
President
of the National
Association
of Negroes
and Americans
for
the
Study
of
History
and
Government
Inc.

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Inc.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11826
BIRTH NO.		68-11826		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
MESSLER, OLIVE		11/20/1968 1pm.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
SINAI HOSPITAL OF BALTIMORE, 421 BALTIMORE, MD. 21205		2624, YORKWAY 53-00		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		BALTIMORE CO		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
F	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10/21/02	65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
DENTAL ASSISTANT				N.Y.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
GARY LEROY WOODRUFF		ELIZABETH FOLEY		U.S.A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO				MRS GLORIA HARTMAN 2624 YORKWAY
18. 451.9 I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Pulmonary embolism		
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		GI bleeding		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		Thrombophlebitis		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
		Severe electrolyte imbalance		
18. 464X II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
10-18-68		Lain		NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 10-4-1968 to 11-20-1968, that (I) (we) last saw the deceased alive on 11-20-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
M. NAGATOSHI		11-20-68		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
		SINAI Hospital of Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
BURIAL		11/25/68		BALTIMORE NATIONAL
				BALTIMORE MD
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
NOV 26 1968		Robert E. Johnson		ULLRICH FUNERAL HOME DUNDALK MD



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11827

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **NORMAN MATHIAS PEPERSACK SR**
-NORMAN-----N-----PEPERSACK-2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ November 18, 1968 2:50 P. M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
MARYLAND GENERAL HOSPITAL (DOA)3. DATE PRONOUNCED DEAD Month Day Year Hour
November 18, 1968 2:50 P. M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY6. SEX
Male7. RACE
White8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN
BaltimoreD. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH

Feb. 20, 1912

10. AGE (In years last birthday) 56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3333 Kentucky Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Mathias A. Pepersack

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

14B. KIND OF BUSINESS OR INDUSTRY

Rugs

15. MOTHER'S MAIDEN NAME

Henrietta Boston

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 1943-194417. SOCIAL SECURITY NO.
215-10-667318. INFORMANT ADDRESS
Mrs. Evelyn Pepersack, 3333 Kentucky Ave.19. **412.4 I**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**422.1 II**
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)**Edward F. Wilson** M.D.
Edward F. Wilson, M.D.CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 19, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)
Burial

24B. DATE

11/21/68

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county) (State)

Parkville, Md.

25A. DATE RECEIVED BY HEALTH DEPT

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Ullrich Funeral Home 4210 Belair Road.

RECEIVED
JAN 10 1969

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11828 CERTIFICATE OF DEATH

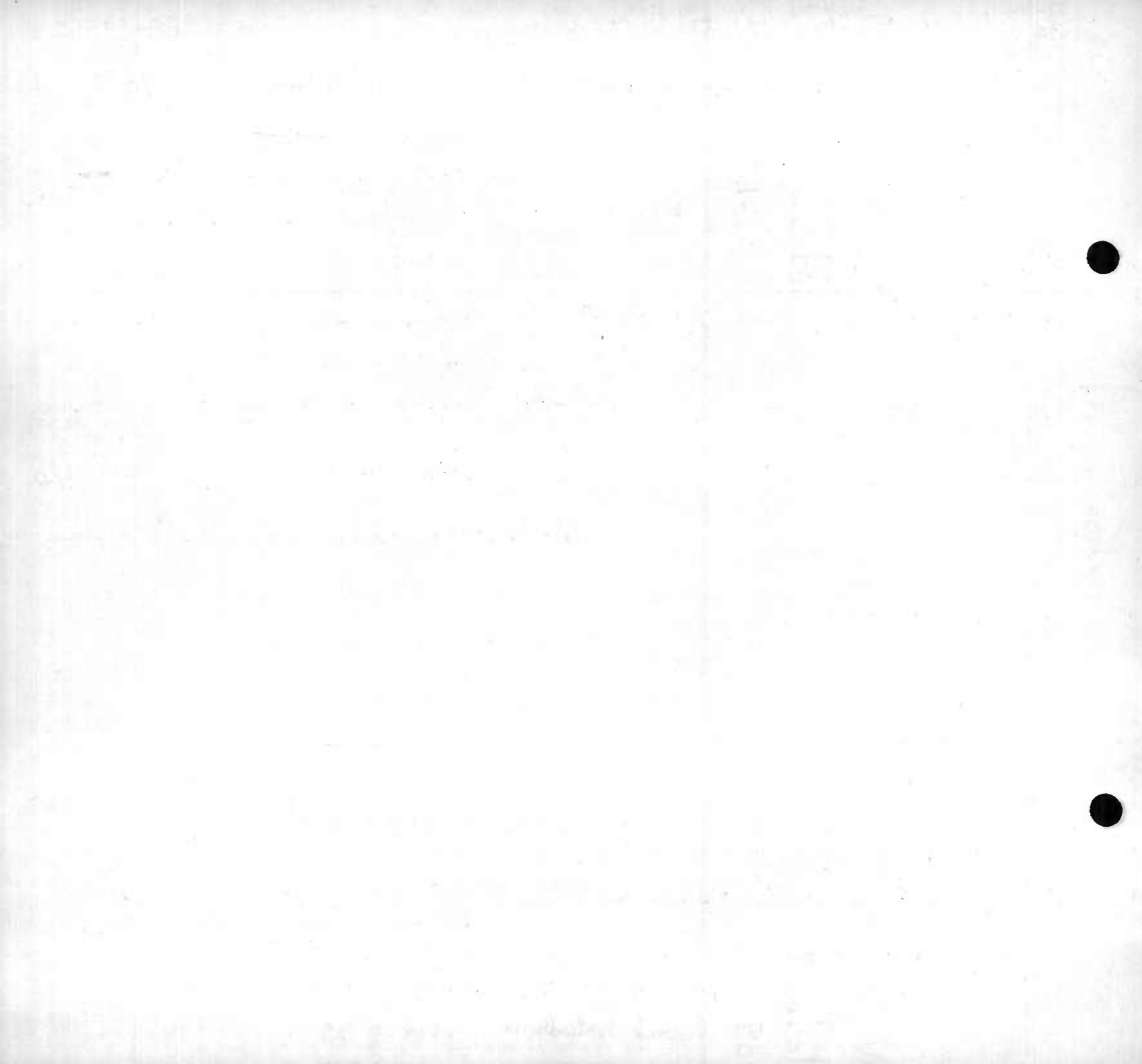
REG. NO. 68-11828

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SCHLAILE, MR. WILLIAM		2. DATE AND HOUR OF DEATH NOV. 20, 1968 8 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home Hospital 35		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2005 Dundalk Ave. (22)	
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH P. 26. 96	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Copper Smith		10B. KIND OF BUSINESS OR INDUSTRY Beth Steel		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Gottlieb Schlaile		14. MOTHER'S MAIDEN NAME Rose Fritz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. 215-09-4568		17. INFORMANT Paulina Schlaile ADDRESS 2005 Dundalk Ave.	
18. 431.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Cerebral Hemorrhage whs. DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331 X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (we) <input checked="" type="checkbox"/> (hospital) attended the deceased from 10-21 19 68 to 10-20 19 68 , that (I) (we) <input checked="" type="checkbox"/> lost saw the deceased alive on 11-20 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE Jose F. Mier M.D. DEGREE				23B. DATE SIGNED 11-20-68	
23C. PHYSICIAN'S NAME (Type) Jose F. Mier M.D. DEGREE				23D. ADDRESS Church Home & Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/23/68		24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY COLGATE MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR UPPICH FUNERAL HOME - DUNDALK MD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. V-525				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11829	
1. NAME OF DECEASED (Type or Print) THOMAS VINCENT				2. DATE AND HOUR OF DEATH 11/19/68 10³⁵ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTO. CITY D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> E. STREET AND NUMBER 1608 DUNDALK AVE. BALTO. MD. 21222			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-00		9. AGE (In years lost birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR			10B. KIND OF BUSINESS OR INDUSTRY AIRPORT LIM. JVC		11. BIRTHPLACE (State or foreign country) CHASE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME THOMAS VINCENT			14. MOTHER'S MAIDEN NAME CARRIE CARSLIE				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-07-4893		17. INFORMANT BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.		
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (B) Metastatic adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 1 year	
19. 199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/8 19 68 to 11/19 19 68 , that (I) (we) lost saw the deceased alive on 11/19 19 68 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William W. Lukenmeyer M.D.				23B. DATE SIGNED 11/19/68			
23C. PHYSICIAN'S NAME (Type) WILLIAM W. LUKENMEYER M.D.				23D. ADDRESS 4940 EASTERN AVENUE BALTIMORE CITY HOSPITAL BALTIMORE, MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 22 NOV. 68		24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETARY		24D. LOCATION (City, town, or county) (State) BALTO. CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ULLRICH FUNERAL HOME-DUNDALK MD		ADDRESS	



H-256

68-11830

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

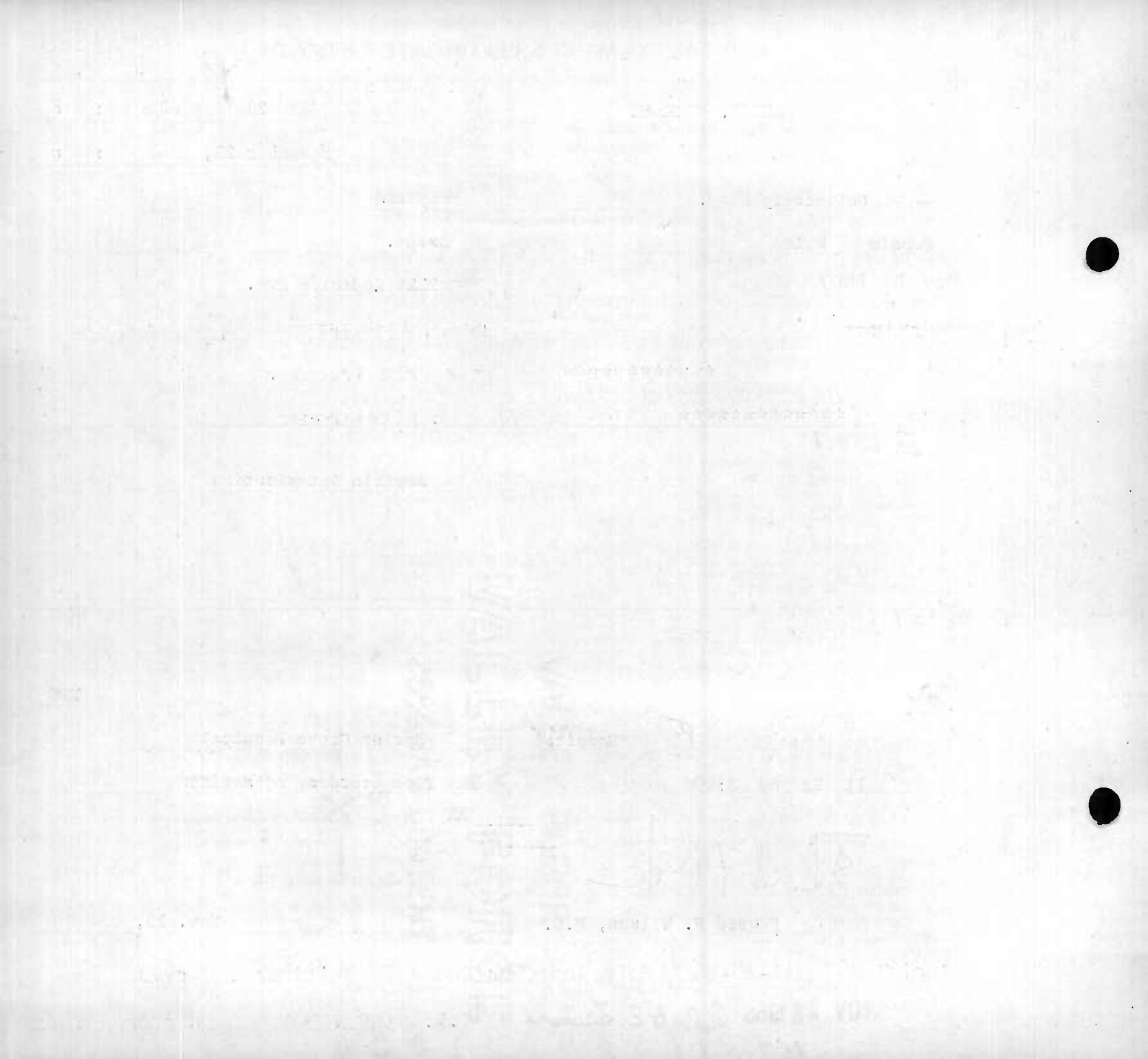
REG. NO.

68-11830

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY C. HECKNER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 23 68 4:40 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hosp.		3. DATE PRONOUNCED DEAD Month Day Year Hour November 23, 1968 4:40 a.m.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH May 14 1907		10. AGE (In years lost birthday) 61	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		15. MOTHER'S MAIDEN NAME Margaret Trageser	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-22-8977	
18. INFORMANT Hospital records		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) E 950.1		CAUSE OF DEATH (A) IMMEDIATE CAUSE Aspirin intoxication DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Spring Grove Hospital		22D. TIME OF INJURY (APPROX.) 11 23 68 3:00p	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Took overdose of aspirin	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Nov. 23, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-26-68	
24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Fink	
25C. FUNERAL DIRECTOR C.F. EVANS & SON		ADDRESS 8802 Harford Rd.	

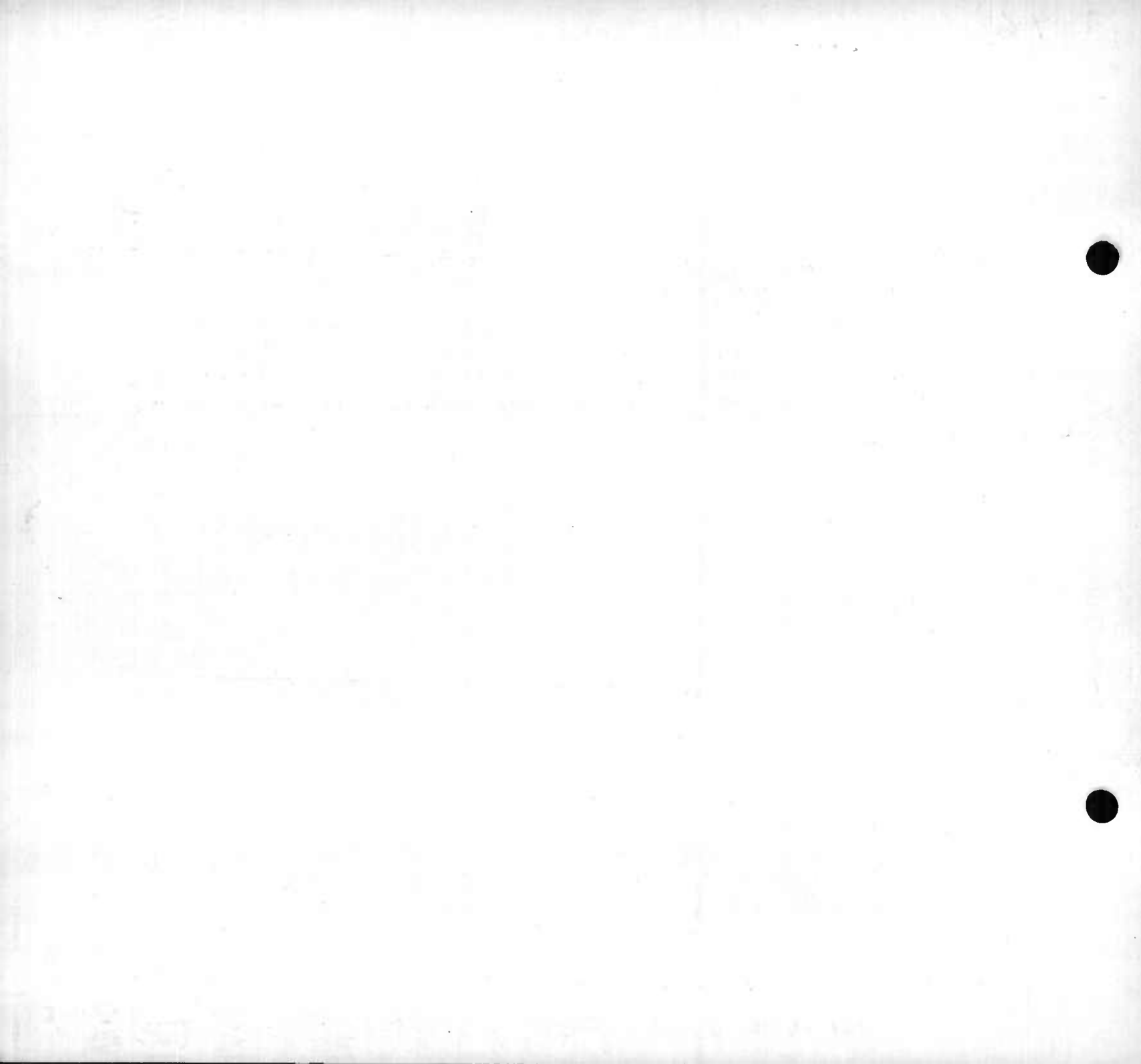
N 965119680021826



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11831	
68-11831				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MR. CARROLL A. MILLER		2. DATE AND HOUR OF DEATH 11-23-68 2³⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 34 Bow SECOURS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY G.A.C. 52-00	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN GLEN BURDIE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		E. STREET AND NUMBER 316 MARYLAND AVE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-6-14		9. AGE (In years last birthday) 54	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE SALES.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN MILLER		14. MOTHER'S MAIDEN NAME ESTELLA KIRK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W W II		16. SOCIAL SECURITY NO. 212-07-1800		17. INFORMANT SAMIE #3 4 ADDRESS MRS Sophia V. Miller	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Cardiac stand still DUE TO, OR AS A CONSEQUENCE OF: 6 min.	
				(B) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: 5 years	
				(C) Massive Cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF: 3 months.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 433.0 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) lost saw the deceased alive on November 23, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gamayor				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) JOSE G. AMAYO		23D. ADDRESS MD.			
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 26 Nov 68		24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK	
24D. LOCATION (City, town, or county) BALTIMORE, Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 26 1968		24F. NAME OF REGISTRAR Robert E. Jenkins	
24G. DATE REC'D BY HEALTH DEPT. NOV 26 1968		24H. NAME OF REGISTRAR Robert E. Jenkins		24I. FUNERAL DIRECTOR KIRKLEY Funeral Home, GLEN BURDIE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11832</u>
BIRTH NO. <u>68-11832</u>				
1. NAME OF DECEASED (Type or Print) <u>VIRGINIA A. AUER</u>		2. DATE AND HOUR OF DEATH <u>11-20-68</u> <u>2</u> PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Harford</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Md. General Hosp.</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>25-04</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/02</u>	9. AGE (In years last birthday) <u>66</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ba Hc</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry Adams</u>		
14. MOTHER'S MAIDEN NAME <u>Laura Jennings</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>217-22-1237</u>		17. INFORMANT <u>Hosp. international sheet</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral neoplasm</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>193.0 II</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>6 Glioblastoma multiforme</u>		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION <u>11-20-68</u>		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain tumor</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>10/21</u> 19 <u>68</u> to <u>11/22</u> 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>11-20-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Marvin C. Sachs, MD</u>				23B. DATE SIGNED <u>11-20-68</u>
23C. PHYSICIAN'S NAME (Type) <u>MARVIN C. SACHS</u>				23D. ADDRESS <u>Md. Gen. Hosp.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>11-21-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Green Mount</u>
24D. LOCATION <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 26 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Jones</u>		25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home, Inc.</u>		
25D. ADDRESS <u>6500 York Rd. Baltimore, Md. 21212</u>				

V. 1000 1. 1000

Mr. General Ford

F. W. X

Harold Adams

10/10/62

10/10/62

10/10/62

Harold Adams

Central 1. 1000

10-01 or 10-01 1000

10/10/62

10-01

Mr. General Ford

Mr. General Ford

Mr. General Ford

10-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11833
BIRTH NO.		68-11833		
1. NAME OF DECEASED (Type or Print) Lillie May Mary Strawbridge		2. DATE AND HOUR OF DEATH November 21, 1968 9:50 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Penna. B. COUNTY York		
FULL NAME OF HOSPITAL OR INSTITUTION House in The Pines Nursing Home		C. CITY OR TOWN Fawn Grove		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5837 Bel Air Road		E. STREET AND NUMBER		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/1891	9. AGE (In years lost birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Howard L. Schilling		
14. MOTHER'S MAIDEN NAME Mary Rebecca Heaps		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 215-12-1814		17. INFORMANT Howard L. Schilling ADDRESS 4515 White Ave. Balto. Md 21206		
18. 599.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Septicemia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Urinary Tract Infection		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 609X II		(B) DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 609X II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from October 22, 1968 to November 21, 1968 , that (I) (we) last saw the deceased alive on November 20, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Albert B. Bradley		23B. DATE SIGNED 11/22/68		23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.
23D. ADDRESS 4900 Belair Road 21206		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 11/24/1968		24C. NAME OF CEMETERY or CREMATORY Ayres Chaple		24D. LOCATION (City, town, or county) (State) White Hall, Harford, Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Jarrett		25C. FUNERAL DIRECTOR ADDRESS Charles E. Kurtz Jarrettsville, Md.

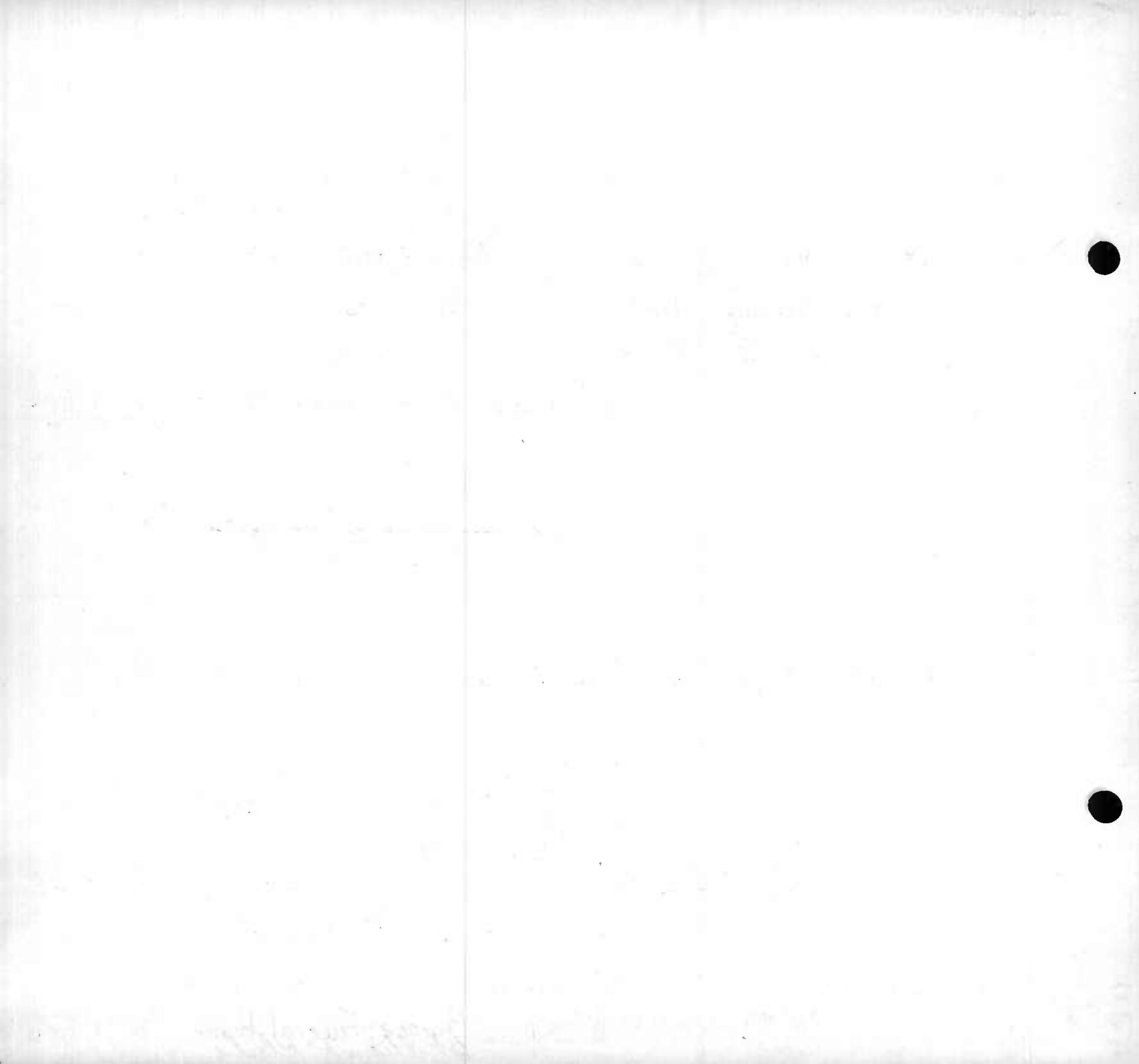
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11834 CERTIFICATE OF DEATH

REG. NO. 68-11834

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Charles B. Wax</i>		2. DATE AND HOUR OF DEATH <i>Nov 22, 1968 11 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 509 W. 28th St.</i>			A. STATE <i>Maryland</i> , B. COUNTY <i>Baltimore City</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>509 W 28th Street</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 18, 1905</i>	9. AGE (In years last birthday) <i>63</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sheet Metal Mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Metal</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Charles D. Wax</i>			14. MOTHER'S MAIDEN NAME <i>Sena</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>230-24-5266</i>		17. INFORMANT <i>James Wax</i>
			ADDRESS <i>2028 Girard Ave.</i>		
18. <i>161.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Metastatic Carcinoma</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>72 yrs.</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of Larynx</i>		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
MEDICAL CERTIFICATION					
161X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):					
19A. DATE OF OPERATION <i>Sept. 20, 1968</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Pharyngocutaneous Fistula</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug. 15</i> 1968 to <i>Sept. 30</i> 1968, that (I) (we) last saw the deceased alive on <i>Sept. 30</i> 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Miguel R. Alonso, M.D.</i>				23B. DATE SIGNED <i>Nov. 25, 1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Miguel R. Alonso</i>				23D. ADDRESS <i>Greater Baltimore Medical Center</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/25/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Crest Lawn</i>	
24D. LOCATION <i>Howard County, Md.</i>					
25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 26 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Burges Funeral Home</i>	
				ADDRESS <i>3631 Falls Rd</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>68-11835</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>68-11835</u> CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>Rev. Charles H. Reed Sr.</u> <u>Rev. Charles H. Reed</u>			2. DATE AND HOUR OF DEATH <u>11/24/68</u> <u>5:00A M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto. Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Dundalk</u> D. STREET ADDRESS (If rural, give location) <u>18 Seabright Ave.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>12/4/1900</u>	AGE (In years last birthday) <u>67</u>	II Under 1 Yr. Months: Days: Hours: Min. II Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Minister</u>			11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Samuel J. Reed</u>			14. MOTHER'S MAIDEN NAME <u>Lizzie M.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>158-09-14761</u>		
17. INFORMANT <u>Dundalk, Md. 21222</u> <u>Calvin E. Maynard, 822 Oakleigh Beach Ave.</u>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Ischemia</u> <u>Stroke</u> <u>Congestive Heart failure</u> <u>Atherosclerosis, generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>335-X II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>November 8th</u> 19 <u>68</u> to <u>November 24th</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>November 24th</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael Yen</u> M.D.				23B. DATE SIGNED <u>11/24/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael Yen</u> M.D.				23D. ADDRESS <u>Maryland General Hospital, Balto. Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/27/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 26 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John J. Duda, 7922 Wise Ave. Dundalk, Md.</u>	

16 September 1960

1/4 1960

White Mountain

Retired

1000 ft

1000 ft

P-662

68-11836 BALTIMORE CITY HEALTH DEPARTMENT

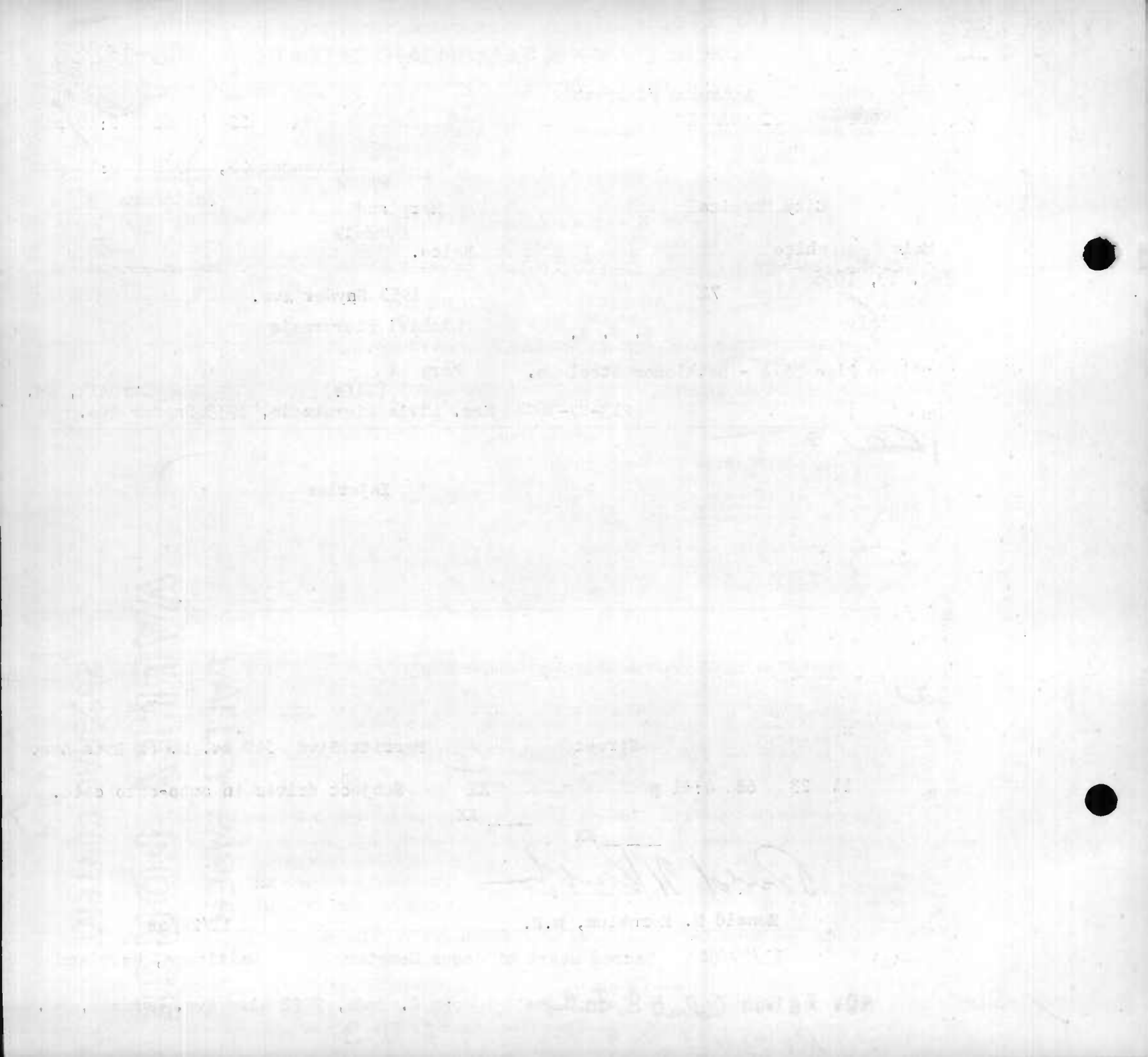
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11836

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Antonino Pierorazio		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 23 68 9:10 p M.	
ANTONINO PIERORAZIO		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 City Hospital		3. DATE PRONOUNCED DEAD November 23, 1968 9:10 p M.	
6. SEX Male		7. RACE white		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 53-00	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH Feb. 13, 1896		10. AGE (In years last birthday) 72		E. STREET AND NUMBER 1953 Snyder Ave.	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Michael Pierorazio	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pipe Mill - Bethlehem Steel Co.		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO 215-07-3894		18. INFORMANT (Wife) Mrs. Livia Pierorazio, 1953 Snyder Ave.	
19. E812.01		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Injuries			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
19. E816.4		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Merritt Blvd 540 ft. N. of Ives Lane	
22D. TIME OF INJURY (APPROX.) 11 23 68 4:11 p		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject driver in auto-auto coll.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/24/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/68		24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Seabury, Jr.	
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.					

N 869.6 9 6 8 0 0 2 1 8 3 2



FUNERAL DIRECTOR: IMPORTANT

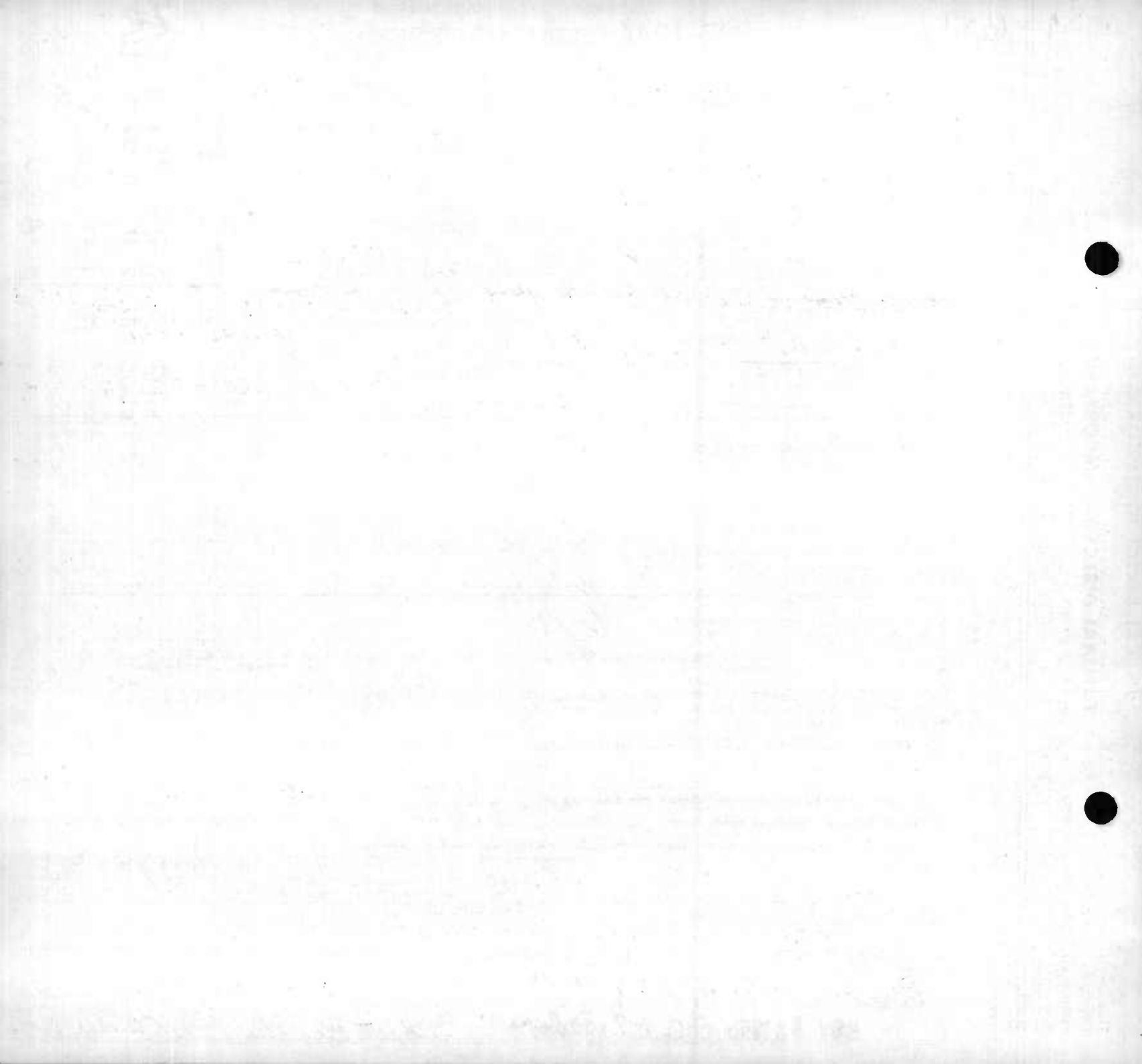
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11837 CERTIFICATE OF DEATH

REG. NO.

10
68-11837

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>DANIEL MARSHALL</i>		2. DATE AND HOUR OF DEATH <i>11-22-68</i> <i>7pm</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTO</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Melchor Nursing Home</i> <i>2327 N Charles St.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>2203 Huntington Ave</i>	
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 16-1896</i>	9. AGE (In Years last birthday) <i>82</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MAINTENANCE SUPERVISOR</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>UNIVERSITY OF MARYLAND</i> <i>retired</i>		11. BIRTHPLACE (State or foreign country) <i>Besenti, Italy</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Italy</i>		13. FATHER'S NAME <i>Fidelia D. Massimonia</i>		14. MOTHER'S MAIDEN NAME <i>MARIA, Iobbi</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-245415A</i>		17. INFORMANT <i>FAMILY</i> ADDRESS <i>2203 HUNTINGTON AVE.</i> <i>Lola E. Johnson</i> <i>SPW</i>	
18. <i>412.4</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic Cardio-vascular Disease</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Cardio-vascular Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Seventy years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>422.1</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (U) (this hospital) attended the deceased from <i>Oct. 19 60</i> to <i>Nov. 19 68</i> , that (I) (we) last saw the deceased alive on <i>Nov 21 19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Loy M. Zimmerman M.D.</i>		23B. DATE SIGNED <i>11/22/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11/26/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>NEW CATHEDRAL</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO., Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 26 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>J. H. Galt</i>		25D. ADDRESS <i>5444 BELAIR Rd.</i>			



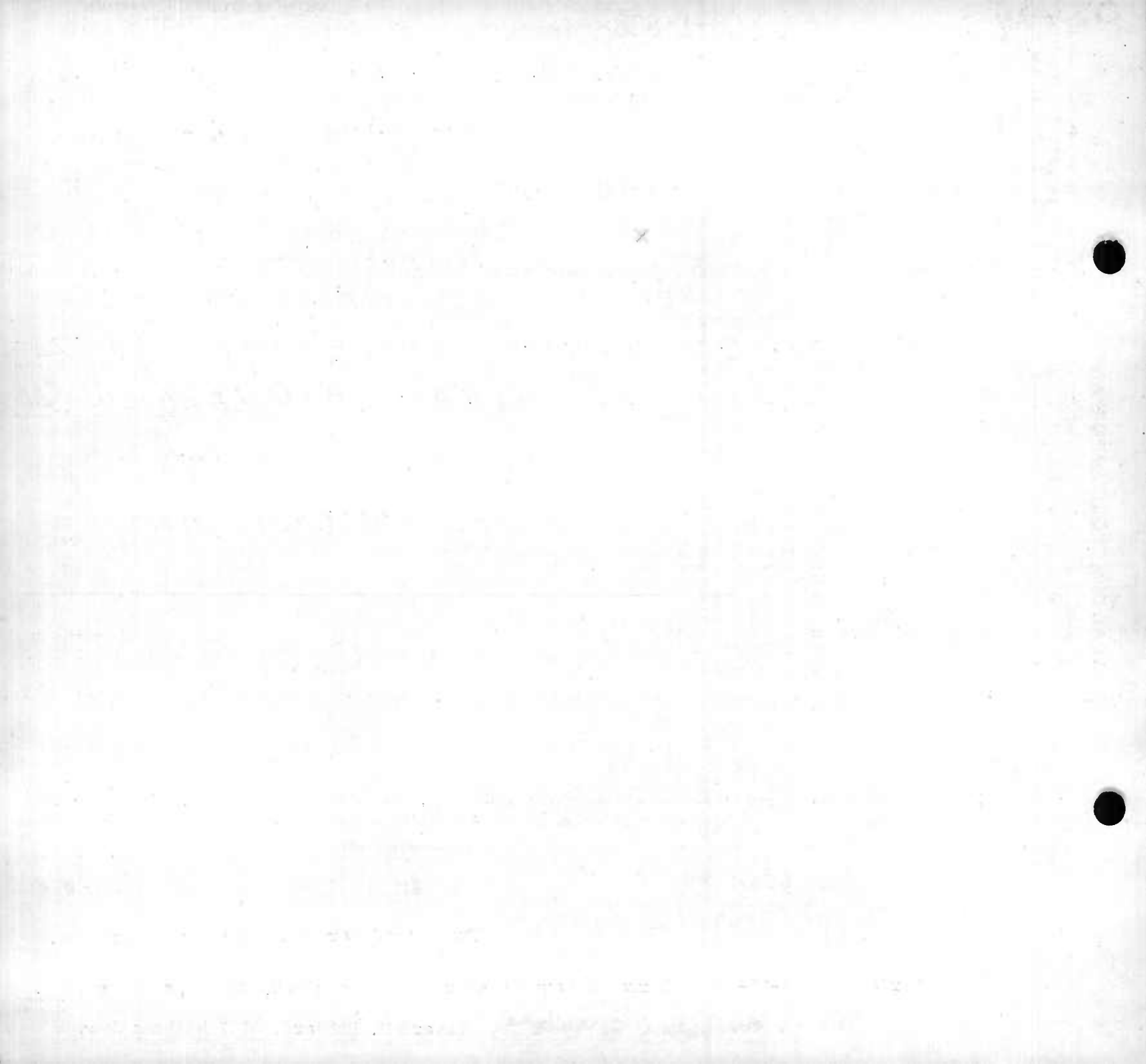
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11838 CERTIFICATE OF DEATH

REG. NO. 68-11838

BIRTH NO.		1. NAME OF DECEASED (Type or Print) O' LOUGHLIN, WILLIAM HENRY		2. DATE AND HOUR OF DEATH NOV 24, 68 7:30 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 36 FRANKLIN SQUARE HOSP			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ALBANY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER W YETH 605 ST 30		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/17/90	9. AGE (In years lost birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A			13. FATHER'S NAME WILLIAM O' LOUGHLIN		
14. MOTHER'S MAIDEN NAME CATHERINE LUTZ			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		
16. SOCIAL SECURITY NO. 216-01-4404			17. INFORMANT MATILDA O' LAUGHLIN SAME		
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIO SCLEROTIC HEART			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.0 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-24 19 68 to 11-24 19 68 , that (I) (we) last saw the deceased alive on 11-24 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Vanasin				23B. DATE SIGNED 11-24-68	
23C. PHYSICIAN'S NAME (Type) C. VANASIN				23D. ADDRESS Franklin Square Hospital, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-27-68		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore City, Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968			
25B. NAME OF REGISTRAR Robert E. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Avenue 21229			



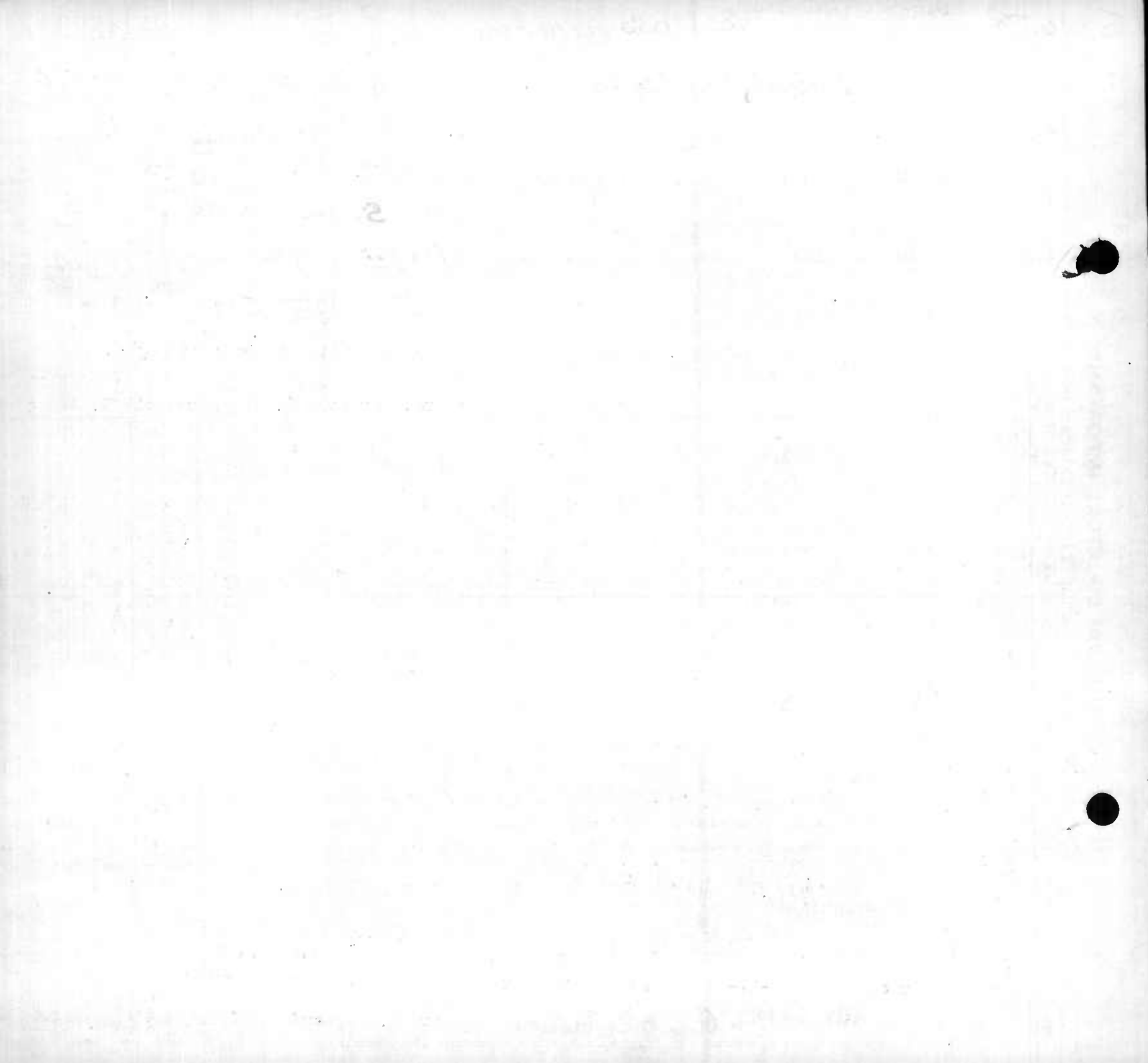
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11839

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11839

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Schubert, Charles XXX G.		11.22.68 12.55 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
36 Franklin Square Hospital				Md. 427 S Bentalou St 23	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES NO	
				E. STREET AND NUMBER	
				427 S. Bentalou St #23	
5. SEX	6. RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)
M	W	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3/12/90	78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired				Baltimore, SMD	U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Charles Schubert				Augusta Kesmodel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
NO				218-03-9637	
17. INFORMANT				ADDRESS	
Mrs. Margaret A. Schubert, 427 S. Bentalou				21223	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410.9 I		Pulmonary infarction			
(This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF			
ANTECEDENT CAUSES		Myocardial infarction, Acute + chronic			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		C.H.F. - A.S.C.V.D.			
		(C) Generalized arteriosclerosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11.06.68 19 to 11.22.68 19 that (I) (we) last saw the deceased alive on 11.22.68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
M. Afzal M.D.				11.22.68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
M. Afzal M.D.				Franklin Sq Hospital 100 N. Calhoun St	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11-26-68		Woodlawn Cemetery	
		24D. LOCATION (City, town, or county) (State)			
		Woodlawn, Maryland			
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 26 1968		Robert E. Schubert		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11840 CERTIFICATE OF DEATH

REG. NO.

68-11840

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Elizabeth V. Mohrlein		2. DATE AND HOUR OF DEATH 11- 22- 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in the Pines Belverde				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Box 678 Kingsville, Md 21087			
5. SEX Female	6. RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-1886	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George A. Kerns				14. MOTHER'S MAIDEN NAME Martha Rubincam			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-5550D		17. INFORMANT Mrs Evelyn Bennett		ADDRESS 4320 Fitch Ave 21236	
18. 1890 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Coronary of Kidney ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Heart Block				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 5 yrs.			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 180X II							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from October 28 19 63 to Nov 14 19 68 , that (I) (we) last saw the deceased alive on Nov 14 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Samuel Whitehouse				23B. DATE SIGNED 11/25/68			
23C. PHYSICIAN'S NAME (Type) Samuel Whitehouse, M.D.				23D. ADDRESS 3900 North Charles Street 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-26-1968		24C. NAME of CEMETERY or CREMATORY Louisa Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Harbison		25C. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 7401 Delair Road	

Hand Book

Jan 14, 1884

1884

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		68-11841		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		68-11841	
M.E. CASE NO.		68-23050		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		Baker, Vegas Terrill (B.B. Ridgely)		2. DATE AND HOUR OF DEATH		11/15/68		1:30 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		MARYLAND		A.A.		52-00	
33 THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN		(If outside city limits, write RURAL and give township)		SEVERNA PARK	
				D. STREET ADDRESS		(If rural, give location)		ROUTE #2 BOX 262	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
male		Negro.		NEVER MARRIED		11/15/68		XXXXX	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
None				BALTIMORE, MD		U.S.A.			
13. FATHER'S NAME		BAKER		14. MOTHER'S MAIDEN NAME		PATRICIA RIDGEEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No									
18. 776.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH		5 hrs.			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO		prematurity; hyaline membrane disease.					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO							
ANTECEDENT CAUSES		(C) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
773.5 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				yes.		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
1 Month (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Nov. 15 1968 to Nov 15 1968		that (I) (we) lost saw the deceased alive on Nov. 15 1968		and that in (my) (our) opinion death occurred on the date Nov. 15 1968		and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED		11/15/68	
PETER NISSLEY									
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
PETER NISSLEY		THE JOHNS HOPKINS HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
CREMATION		11-16-68		Johns Hopkins Hospital		BALTO, MD.			
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
NOV 26 1968		Robert E. Tabor		HOSPITAL DISPOSAL					

U.S.A.

BALTIMORE, MD

None

No

no

✓

MD

BALTO.

11-16-68 Johns Hopkins Hospital

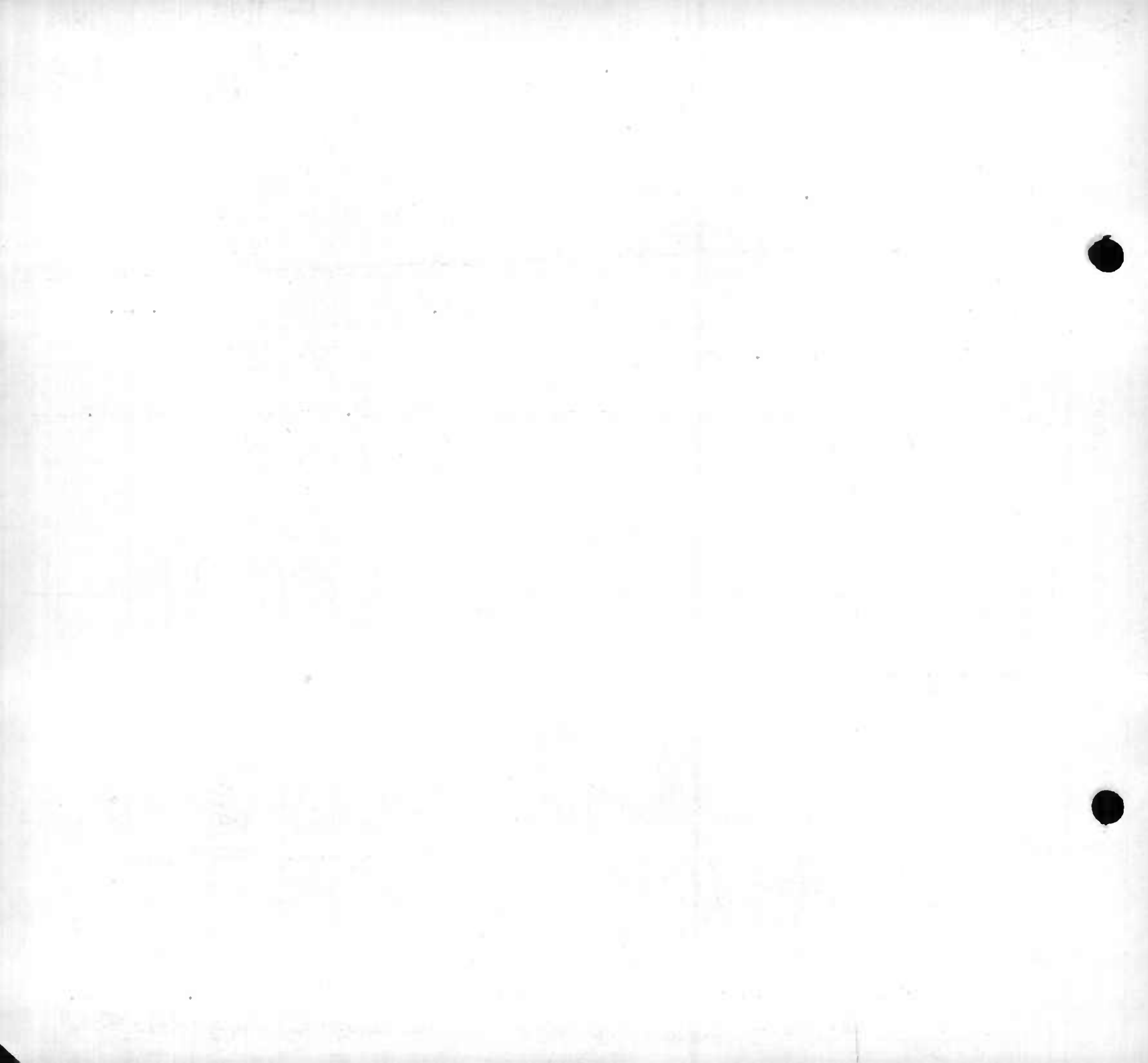
CRIMINAL

1968-11-16-68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11842
68-11842 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mrs. MABEL P. ROWE</i>		2. DATE AND HOUR OF DEATH <i>11/22/68 8:55A</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>48 Md. General Hospital</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>53-00</i>		
			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>4320 Fitch Avenue 21236</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-1-1886</i>	9. AGE (In years lost birthday) <i>82</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>	
13. FATHER'S NAME <i>George A. Berns</i>		14. MOTHER'S MAIDEN NAME <i>Martha Rubincam</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216-09-5550D</i>		17. INFORMANT <i>Mrs Evelyn V. Bennett 4320 Fitch Ave. 21236</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <i>Infarction of midbrain cerebral thrombosis</i> (B) DUE TO, OR AS A CONSEQUENCE OF <i>ASCVD - pneumonia</i> (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>422.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>No</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8:15 11/7/68</i> to <i>11/22/68</i> and that (I) (we) last saw the deceased alive on <i>11/7/68</i> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. S. Tilley</i>				23B. DATE SIGNED <i>11/22/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. TILLEY</i>		23D. ADDRESS <i>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-25-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 26 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Lassan Funeral Home 7401 Belair Road 2</i>			



B-356

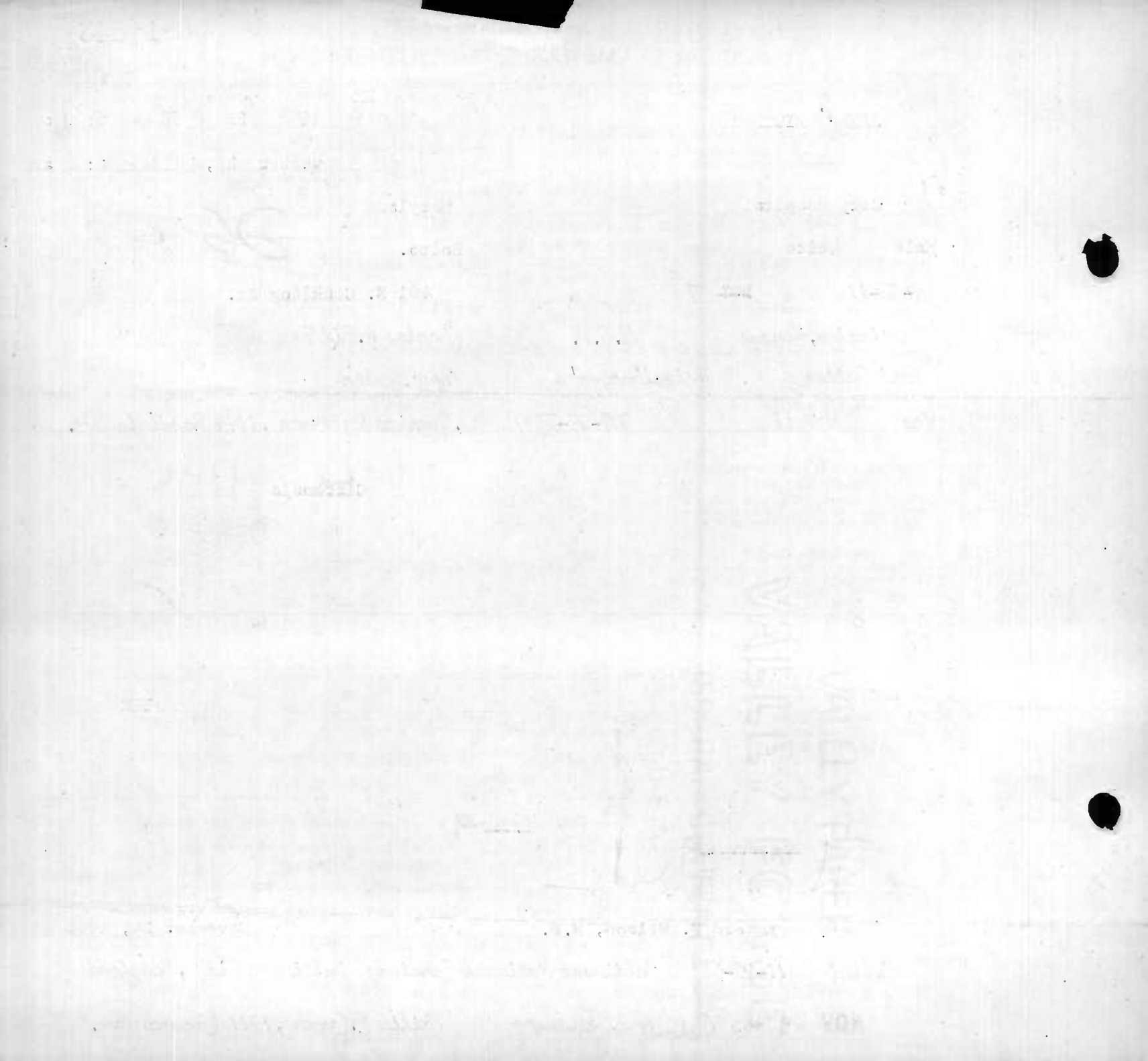
68-11843 BALTIMORE DEPARTMENT

68-11843

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) JAMES BITTNER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 11 Day 23 Year 68 Hour 6:00 a.m. Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month November Day 23 Year 1968 Hour 6:00 a.m.	
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 9-30-11		10. AGE (In years last birthday) 50-57		11. BIRTHPLACE (State or foreign country) Hertington, Kansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles N. Bittner		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter	
15. MOTHER'S MAIDEN NAME Anna Bealer		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		17. SOCIAL SECURITY NO. 509-09-7339	
18. INFORMANT Mrs. Bernice Dutterer		ADDRESS 1114 Rosedale Ave.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cirrhosis		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 5-8-60		(B) DUE TO, OR AS A CONSEQUENCE OF:			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Edward F. Wilson		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-26-68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore City, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Philip E. Crach		ADDRESS 1211 Chesaco Ave.			



5-300

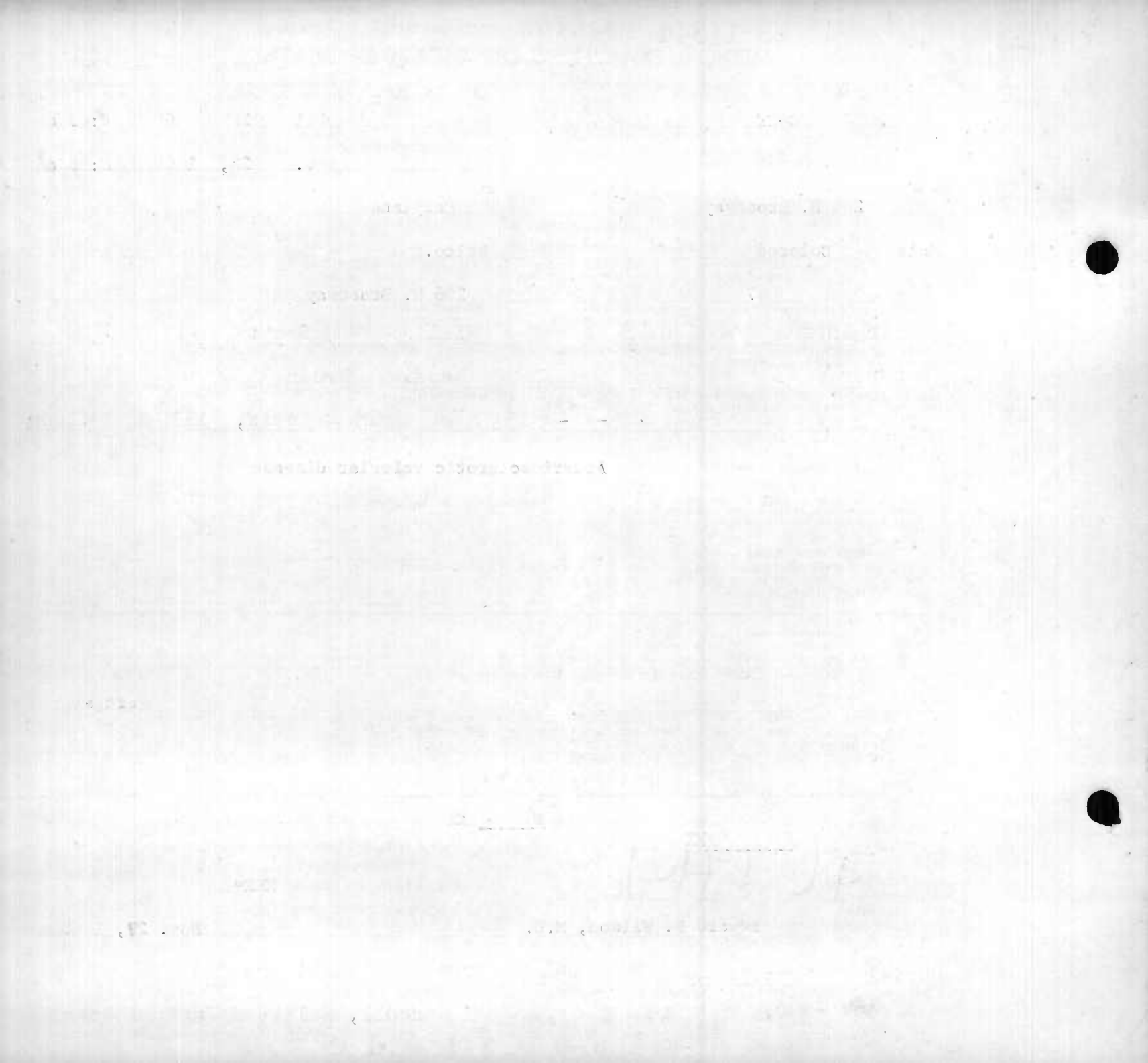
68-11844 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11844

BIRTH NO.

1. NAME OF DECEASED (Type or Print) AMOS SCOTT (Amos W Scott)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 11 Day 23 Year 68 Hour 8:05 a.m. Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 206 N. Broadway		3. DATE PRONOUNCED DEAD Month Nov. Day 23 Year 1968 Hour 8:05 a.m.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto.	
6. SEX Male	7. RACE Colored	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 206 N. Broadway	
9. DATE OF BIRTH 9/20/20	10. AGE (in years lost birthday) 47	11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME William H Scott	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Bessie Brown	
15. MOTHER'S MAIDEN NAME Bessie Brown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W W 2	
17. SOCIAL SECURITY NO. 229-14-0913		18. INFORMANT M's Camay C Lewis, 1118 N Milton Ave	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic valvular disease (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 427.4 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 68-11845	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
22A. DATE OF OPERATION 2		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22E. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22G. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22H. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/29/68	
24C. NAME OF CEMETERY or CREMATORY National Cemetry		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR I Carroll, Halstead Funeral Home		ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11845

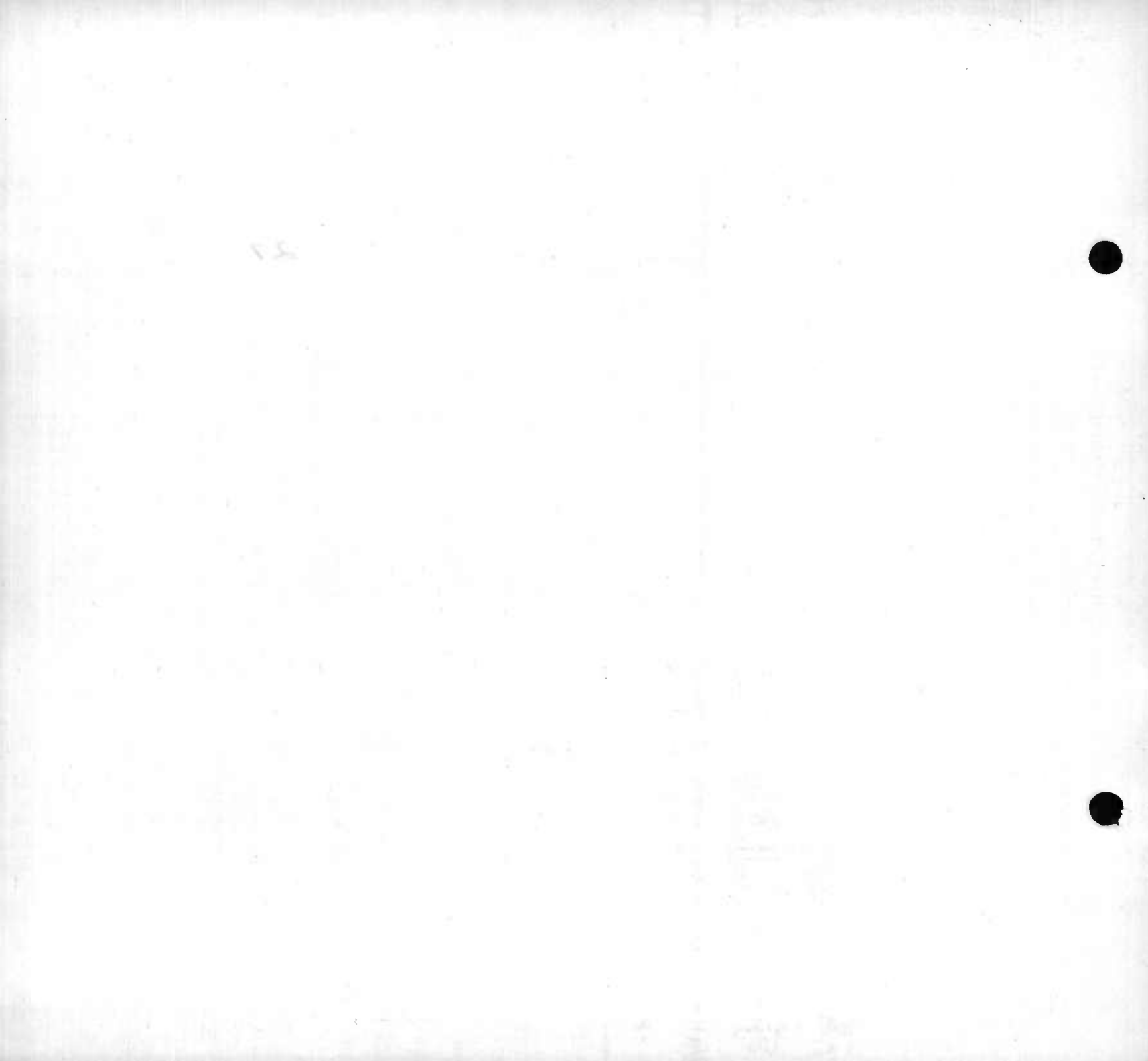
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>George Francis Barnes</u>		2. DATE AND HOUR OF DEATH <u>11/22/68</u> <u>1245P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALT CITY</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>MD: GENERAL HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>COMMON LAW WIFE</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		8. DATE OF BIRTH <u>?</u>	
13. FATHER'S NAME <u>George Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Mary Clark</u>		9. AGE (In years last birthday) <u>50 ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-18-8807</u>		17. INFORMANT <u>Hosp. ADM. CHART</u>	
18. <u>403X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>INTRACEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>HYPERTENSION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>RENAL DISEASE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS.</u> <u>?</u> <u>?</u>	
19. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>11/20</u> 19 <u>68</u> to <u>11/22</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kathryn Anderson</u>				23B. DATE SIGNED <u>11/22/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>—</u>				23D. ADDRESS <u>—</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/29/68</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 28 1968</u>			
25B. NAME OF REGISTRAR <u>R. B. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>I. Carroll</u>			
ADDRESS <u>Halstead Funeral Home</u> <u>1206 W North Ave</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11846	
1. NAME OF DECEASED (Type or Print) FANNIE MINOR		2. DATE AND HOUR OF DEATH 11/22/68 12:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIV Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD B. COUNTY BAITO	
		C. CITY OR TOWN BAITO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 919 W Lexington ST.			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/41	9. AGE (In years last birthday) 27	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Horace Minor		14. MOTHER'S MAIDEN NAME Mildred Bryant	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Chart	
18. 303.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Ischemia (B) Hypoglycemia DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic Malnutrition Alcohol		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 32.2.1 II		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/30 19 68 to 11/22 19 68 , that (I) (we) last saw the deceased alive on 11/21/68 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ES Caplan MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/22/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS UNIV Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/27/68		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Fyfe	
25C. FUNERAL DIRECTOR I Carroll, Halstead Funeral Home		25D. ADDRESS 1206 W North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11847

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11847

BIRTH NO.		1. NAME OF DECEASED (Type or Print) DONELLA LAWSON		2. DATE AND HOUR OF DEATH 11-20-68 4:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL OF BALTIMORE MD			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2509m Salem St		
5. SEX F	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 8/28/28	9. AGE (In years lost birthday) 40
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Darlington South Caro.	
13. FATHER'S NAME Monroe Curry			14. MOTHER'S MAIDEN NAME Anna		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr John Lawson, Same	
18. 400.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ante Renal Failure & Uremia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Malignant Hypertension (B) DUE TO, OR AS A CONSEQUENCE OF: Constrictive heart failure (C) Pneumonitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 1 week 1 week 1 wk	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 447.8 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/15 19 68 to 11/20 19 68 , that (I) (we) last saw the deceased alive on 11/19 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Howard R. Friedman M.D.				23B. DATE SIGNED 11/20/68	
23C. PHYSICIAN'S NAME (Type) HOWARD R. FRIEDMAN M.D.				23D. ADDRESS Sinai Hosp. of Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/25/68		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION Baltimore Md		24E. ADDRESS North Ave			
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. ADDRESS 1206 W. North Ave	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11848

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ALLEN RICHARDSON				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 24 68 3:00 a M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital D.O.A.				3. DATE PRONOUNCED DEAD Month Day Year Hour November 24, 1968 3:00 a M.			
6. SEX Male		7. RACE Colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 4/25/47		10. AGE (In years last birthday) 21		11. BIRTHPLACE (State or foreign country) MD		E. STREET AND NUMBER 5112 St. Georges Ave.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				14B. KIND OF BUSINESS OR INDUSTRY AMERICAN SMELTING			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) YES VIETNAM				17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME PEARL JEAN RICHARDSON	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E965X I				CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wound to chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). E981X II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Outside of 740 Glenwood				22F. HOW DID INJURY OCCUR? Shot during altercation			
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 11 24 68 4:30				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Nov. 24, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/28/68		24C. NAME OF CEMETERY or CREMATORY BALTO. NATIONAL		24D. LOCATION (City, town, or county) (State) 5501 FREDERICK AVE	
25A. DATE REC'D BY HEALTH DEPT. NOV 28 1968		25B. NAME OF REGISTRAR John E. Jones		25C. FUNERAL DIRECTOR Joseph B. Rock		ADDRESS 1304 N. Central Ave	

WALL

RECEIVED

[Handwritten signature]

Edward J. Walsh, M.D.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11849

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) CHARLES C. ALBAUGH (Clinton)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 24, 1968		Hour 10:17 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 24, 1968		Hour 10:17 P.M.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		B. COUNTY Anne Arundel	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Pasadena	
9. DATE OF BIRTH Sept 2, 1914		10. AGE (In years last birthday) 54		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 108 Sandy Beach Dr.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		14B. KIND OF BUSINESS OR INDUSTRY Railroad (W.Md.)		15. MOTHER'S MAIDEN NAME Caroline Leo	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 218 03 7204		18. INFORMANT Ruby A. Albaugh (Wife)	
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 29, 68		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem.	
24D. LOCATION (City, town, or county) (State) Balto County Md.		24E. NAME OF REGISTRAR CURTIS E. EVANS		24F. ADDRESS 1400 S. Charles Balto Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR 21230	

(Citation)

Sept 1 1914

24

Baltimore, Md.

USA

Business

Ballroom (W.M.) Caroline Lee

218 02 7000 Emily A. Aldrich (Wife)

WALLACE B. M. B. CO. INC.
218 02 7000

Serial

Nov 22 03

Nov 22 03

Serial 000000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11850

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11850

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LEROY M. NICHOLS		11-25-68 10:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 106 E. Gittings Street	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-14-1895	9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME Zachariah Nichols		14. MOTHER'S MAIDEN NAME Maggie Fleming		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-07-1558		17. INFORMANT Gordon Nichols, 106 E. Gittings St.,	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.0 I This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis + Hypertension caused sudden death (C) DUE TO, OR AS A CONSEQUENCE OF:	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 23, 1949 to Nov. 25, 1968, that (I) (we) last saw the deceased alive on Nov. 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H.P. Friedman M.D.				23B. DATE SIGNED 11/26/68	
23C. PHYSICIAN'S NAME (Type) H.P. FRIEDMAN M.D.				23D. ADDRESS 1319 L. GAIT ST. - BALT. MD. 21230.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-27-68		24C. NAME OF CEMETERY OR CREMATORY Western Cemetery	
24D. LOCATION Edmondson Ave. Baltimore, Md.		24E. DATE RECEIVED FOR HEALTH DEPT. NOV 26 1968		24F. NAME OF REGISTRAR Robert E. Friedman	
24G. DATE RECEIVED FOR HEALTH DEPT. NOV 26 1968		24H. NAME OF REGISTRAR Robert E. Friedman		24I. FUNERAL DIRECTOR Flynn & Fleming, 422 Light St.	



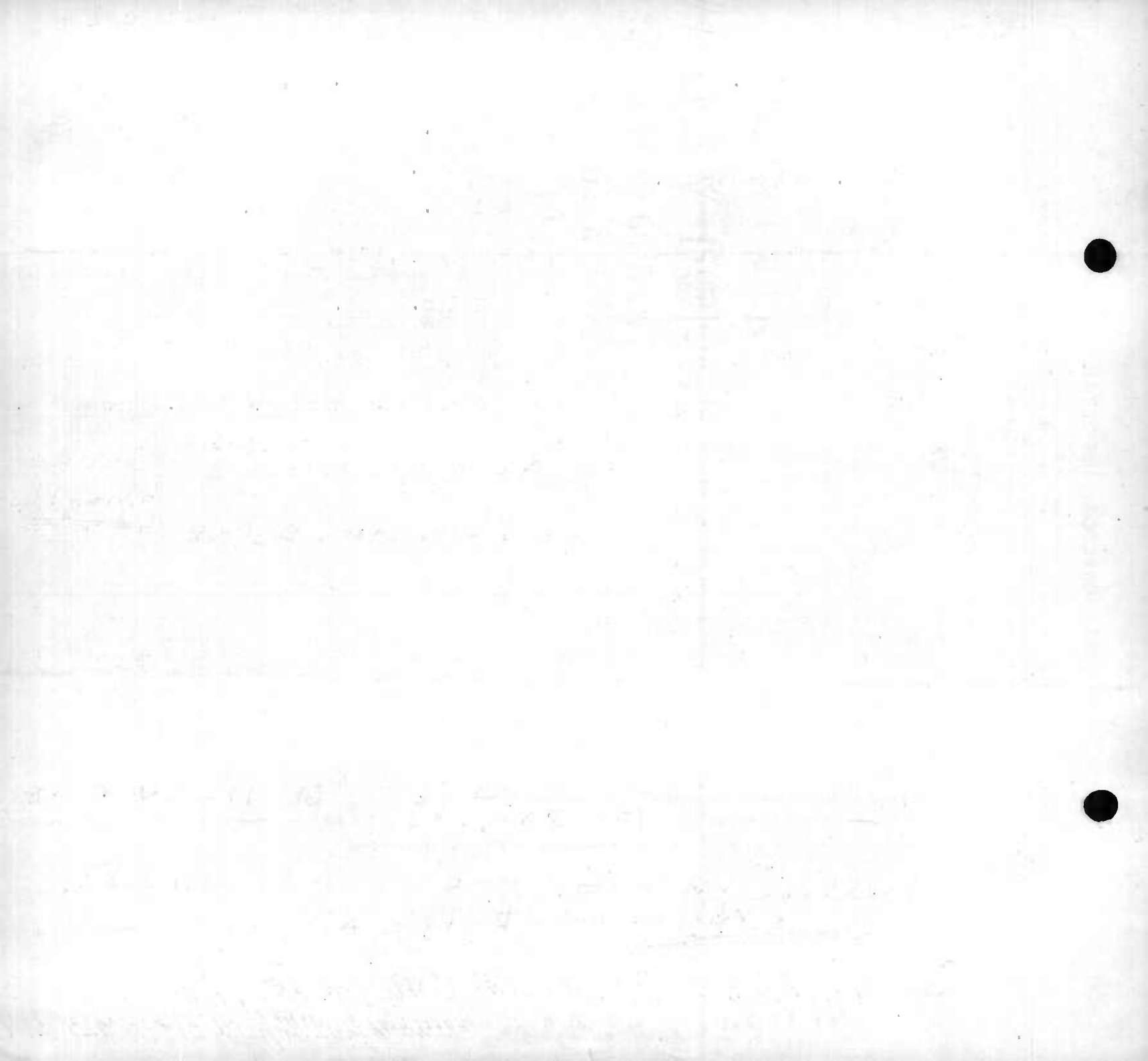
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11851 CERTIFICATE OF DEATH

REG. NO. **68-11851**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mary E. Richards		2. DATE AND HOUR OF DEATH Nov. 24, 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 00 16 S. Schroeder St.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 16 S. Schroeder St.			
5. SEX Female	6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 13, 1923	9. AGE (In years last birthday) 45	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Foster				14. MOTHER'S MAIDEN NAME Virginia Mae Bacon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Granville Richards		ADDRESS 16 S. Schroeder St.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: occlusion Sudden		6 months	
				(B) Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: 6 months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-6 1968 to 11-24 1968 , that (I) (we) last saw the deceased alive on 10-30-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William E. Foster				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11-25-68	
23C. PHYSICIAN'S NAME (Type) William E. Foster				23D. ADDRESS 510 N. Arlington A			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/1968		24C. NAME OF CEMETERY OR CREMATORY W. Paulson Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR William E. Foster		ADDRESS 319 N. Schroeder St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11852 CERTIFICATE OF DEATH

REG. NO. 68-11852

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Evelyn Dupree		2. DATE AND HOUR OF DEATH 11/23/68 7:25PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balto, MD.	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1636 E. 32ND ST.	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-3-35	9. AGE (In years last birthday) 33
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore MD, USA	
13. FATHER'S NAME Otha Hendricks				14. MOTHER'S MAIDEN NAME LUCILLE HENDRIX Alston	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-30-5830		17. INFORMANT Nathaniel Dupree Same	
18. 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CVA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Hypertension DUE TO, OR AS A CONSEQUENCE OF: 15 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No!	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/20 19 68 to 11/23/68 19 68 , that (I) (we) last saw the deceased alive on 5PM 11/23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kevin N. Hennessey				23B. DATE SIGNED 11/23/68	
23C. PHYSICIAN'S NAME (Type) Kevin N. Hennessey				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-27-68		24C. NAME OF CEMETERY or CREMATORY Not known	
24D. LOCATION (City, town, or county) Balto MD		24E. (State) MD			
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Chas. W. ...	
				ADDRESS 1000 Cranberry Pl	

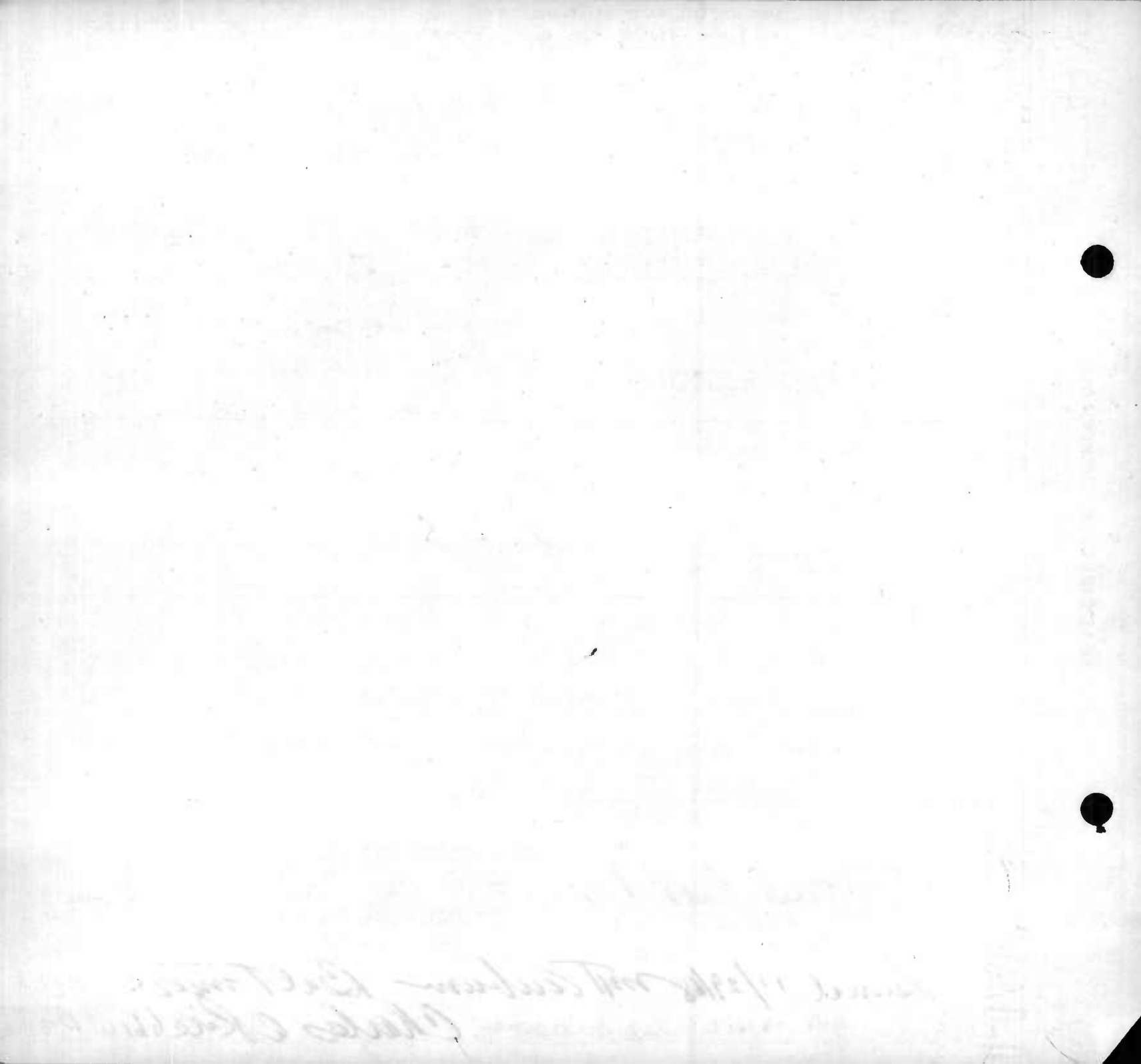
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Tom Howard

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11853	
<div style="display: flex; justify-content: space-between;"> 49-63-80 68-11853 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Jerome B. Hughes</i>		2. DATE AND HOUR OF DEATH <i>11/24/68</i> <i>3:30</i> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND 21224</i>			A. STATE <i>MARYLAND</i> B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>MALE</i>			6. RACE <i>NEGRO</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. DATE OF BIRTH <i>10-25-14</i>		10. AGE (In years last birthday) <i>54</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <i>MARY</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>BCH: RECORDS 4940 EASTERN AVE. BALTO, MD.</i>	
18. <i>348.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Respiratory Failure</i> (B) <i>A.L.S.</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-17</i> <i>1968</i> to <i>11-24</i> <i>1968</i> , that (I) (we) last saw the deceased alive on <i>11-24</i> <i>1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Paul Kalkut</i>				23B. DATE SIGNED <i>11-24-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>PAUL KALKUT M.D.</i>				23D. ADDRESS <i>4940 EASTERN AVENUE BALTIMORE CITY HOSPITAL BALTIMORE, MARYLAND 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>11/29/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mount Auburn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 26 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>	
25C. FUNERAL DIRECTOR <i>Charles C. Rice</i>		25D. ADDRESS <i>661 W. B...</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68-11854 CERTIFICATE OF DEATH

REG. NO. 68-11854

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Edward Dorsey</u>		2. DATE AND HOUR OF DEATH <u>11/21/68 - 4:00 P.M.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>University Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>22-01</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>			C. CITY OR TOWN <u>Baltimore</u>		INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>109 W. Hill St.</u>					
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6/7/09</u>	9. AGE (In years last birthday) <u>59</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Eliash Dorsey</u>			14. MOTHER'S MAIDEN NAME <u>Nellie Davis</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mary Harris</u> ADDRESS <u>1103 S. Sharpe St.</u>	
18. <u>432.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <u>Tentorial Hemiat</u> <u>1 Day</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Rt Cerebral Infarction</u> <u>3 Days</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Rt Int. Carotid Arteriosclerosis</u> <u>3 Days</u>		
MEDICAL CERTIFICATION <u>332X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>—</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>11/18</u> 19 <u>68</u> to <u>11/21</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/21</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Martin J. Schwarte MD</u>				23B. DATE SIGNED <u>11/21/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Martin J. Schwarte MD</u>				23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-26-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 26 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> ADDRESS <u>661 W. Bane St.</u>	

Feb 11 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11855		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11855	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Hartman Pauline ELIZABETH</i>		2. DATE AND HOUR OF DEATH <i>11/24/68 4:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secour Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 6-02</i>			
		D. STREET ADDRESS (If rural, give location) <i>4 N. Lakewood Ave.</i>			
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>8/31/94</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Charles Volk</i>		14. MOTHER'S MAIDEN NAME <i>Mueller</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>212-46-7524</i>		17. INFORMANT ADDRESS <i>REGINA HARTMAN 4 N LAKEWOOD AVE</i>	
18. <i>183.0 I</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Pulmonary edema - Metastatic Ca.</i> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Carcinoma of ovary.</i> DUE TO			
		(C)			
175.0 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>10-26-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CARCINOMA OVARY</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/21/68</i> 19 <i>68</i> to <i>11/24</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/24</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. Achman</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11/24/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>WALTER F. ALBUERNE</i>		23D. ADDRESS M.D. <i>5713 CINCINNATI PKWY - BALTIMORE</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>NOV 27 1968</i>	24C. NAME of CEMETERY or CREMATORY <i>HOLY REDEEMER CEM.</i>		24D. LOCATION (City, town, or county) (State) <i>4430 BELAIR RD BALTO MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 26 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR ADDRESS <i>THE DIPPEL BROS INC 1800 E LOMBARD ST</i>	

68-11856 CERTIFICATE OF DEATH

BIRTH NO. 68-19058		1. NAME OF DECEASED (Type or Print) BABY BOY HOLMES		2. DATE AND HOUR OF DEATH 9-7-68 10:50A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Baltimore, Inc.		E. STREET AND NUMBER 2914 Poplar Terrace			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-68	9. AGE (In years last birthday) 10	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Rosalie Holmes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours	
19. 776X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. HOW DID INJURY OCCUR?	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 9-7 19 68 to 9-7 19 68 , that (I) we lost saw the deceased alive on 9/7 19 68 and that in my our opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE J. Eufemio		23B. DATE SIGNED 9-7-68		23C. PHYSICIAN'S NAME (Type) J. EUFEMIO	
23D. ADDRESS Sinai Hospital of Baltimore		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/24/68	
24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL		24D. LOCATION (City, town, or county) BALTIMORE		24E. STATE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Tashy, Jr.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Marlow

9/14 Fulton Express

9-7-63

Marlow

Bozale

Drumhant

John

2 EUGENIO

Gene Hooten

9-7-63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																		
BIRTH NO. <i>No record</i> 1303690 68-11857					CERTIFICATE OF DEATH					Registered No. 68-11857								
1. NAME OF DECEASED (Type or Print) <i>Smith, Baby G. r L</i>					2. DATE AND HOUR OF DEATH <i>11-8-68 5:10 PM</i> <i>5:10 P</i> M.													
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL</i>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>GRASONVILLE 67-00</i>													
5. SEX <i>Female</i>		6. RACE <i>Negro</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Infant</i>		8. DATE OF BIRTH <i>9/4/68</i>		9. AGE (In years lost birthday) <i>64 days</i>		If Under 1 Yr. Months Days Hours Min. <i>64</i>		If Under 24 Hrs. Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Maryland</i>					12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>WILLIE SMITH</i>					14. MOTHER'S MAIDEN NAME <i>Minnie Smith</i>					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Grasonville, md (PO Box 253)</i>	
18. <i>759.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>multiple congenital anomalies with brain damage</i> DUE TO (B) _____ DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH <i>63 days</i>								
19A. DATE OF OPERATION <i>3-10-26-68</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>great supernumerary toe</i>					20A. AUTOPSY? (Yes or No) <i>YES</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (this hospital) attended the deceased from <i>September 4</i> 19 <i>68</i> to <i>November 8</i> 19 <i>68</i> , that (I) (was) last saw the deceased alive on <i>November 8</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.																		
23A. SIGNATURE <i>Frank A. Simon</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <i>11-8-68</i>								
23C. PHYSICIAN'S NAME (Type) <i>FRANK A. SIMON</i>					M.D. 23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>													
24A. BURIAL CREMATION REMOVAL (Specify) <i>Released 11/26/68</i>					24B. DATE <i>11/26/68</i>					24C. NAME OF CEMETERY OR CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i>					24D. LOCATION (City, town, or county) (State) <i>Baltimore, MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 26 1968</i>					25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>					25C. FUNERAL DIRECTOR ADDRESS <i>MORTUARY SERVICE - BCHD</i>								

14/10/88

14/10/88

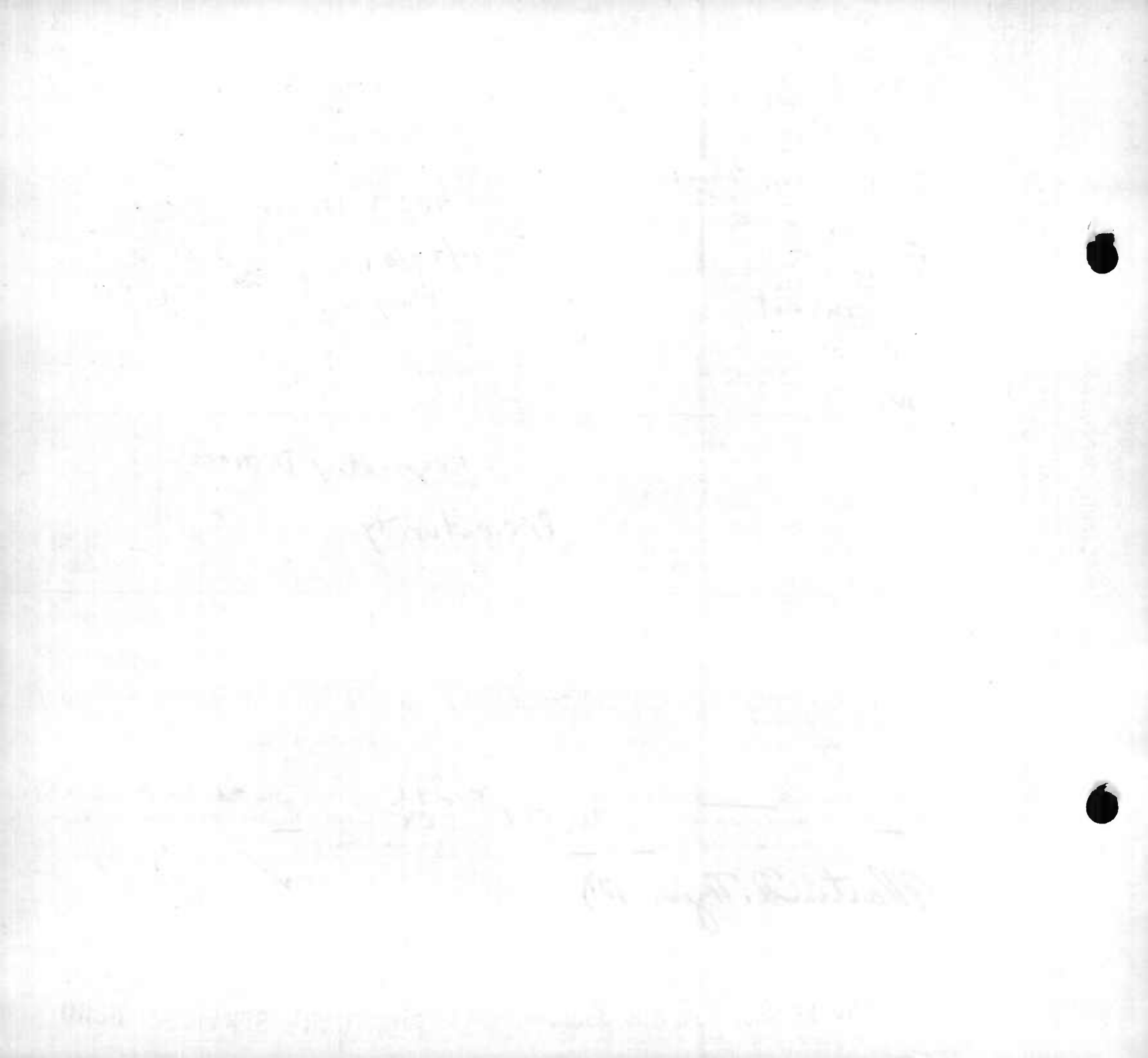
business

business

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

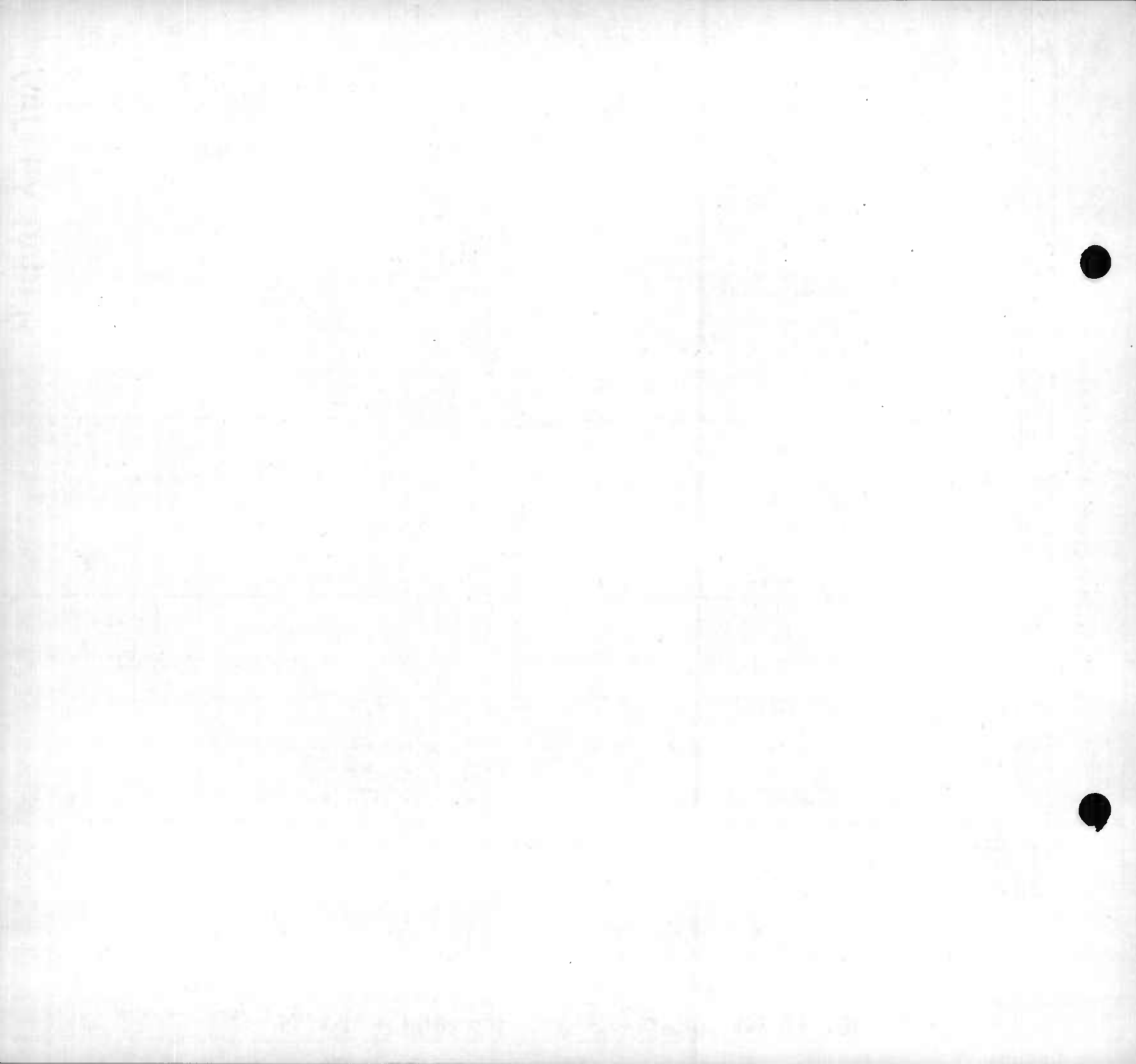
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11858</u>
BIRTH NO. <u>68-20568</u>		68-11858 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Rusk, Baby Girl</u>		2. DATE AND HOUR OF DEATH <u>26 October 1968 2⁵⁸ P M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-16</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital, Baltimore, Md</u> <u>42</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>4603 Homer Avenue</u>		
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/68</u>	9. AGE (In years last birthday) <u>0 2</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Rudolph Johnson</u>		
14. MOTHER'S MAIDEN NAME <u>Sheila Rusk</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>776.21</u> <u>Respiratory Distress</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Prematurity</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>773.5-11</u>				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Birth</u> 19 <u>68</u> to <u>26 Oct</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>26 Oct</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Martin D. Myers MD</u>		23B. DATE SIGNED <u>10/26/68</u>		23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11/26/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>
24D. LOCATION (City, town, or county) (State)		25A. DATE RECEIVED BY HEALTH DEPT. <u>NOV 28 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

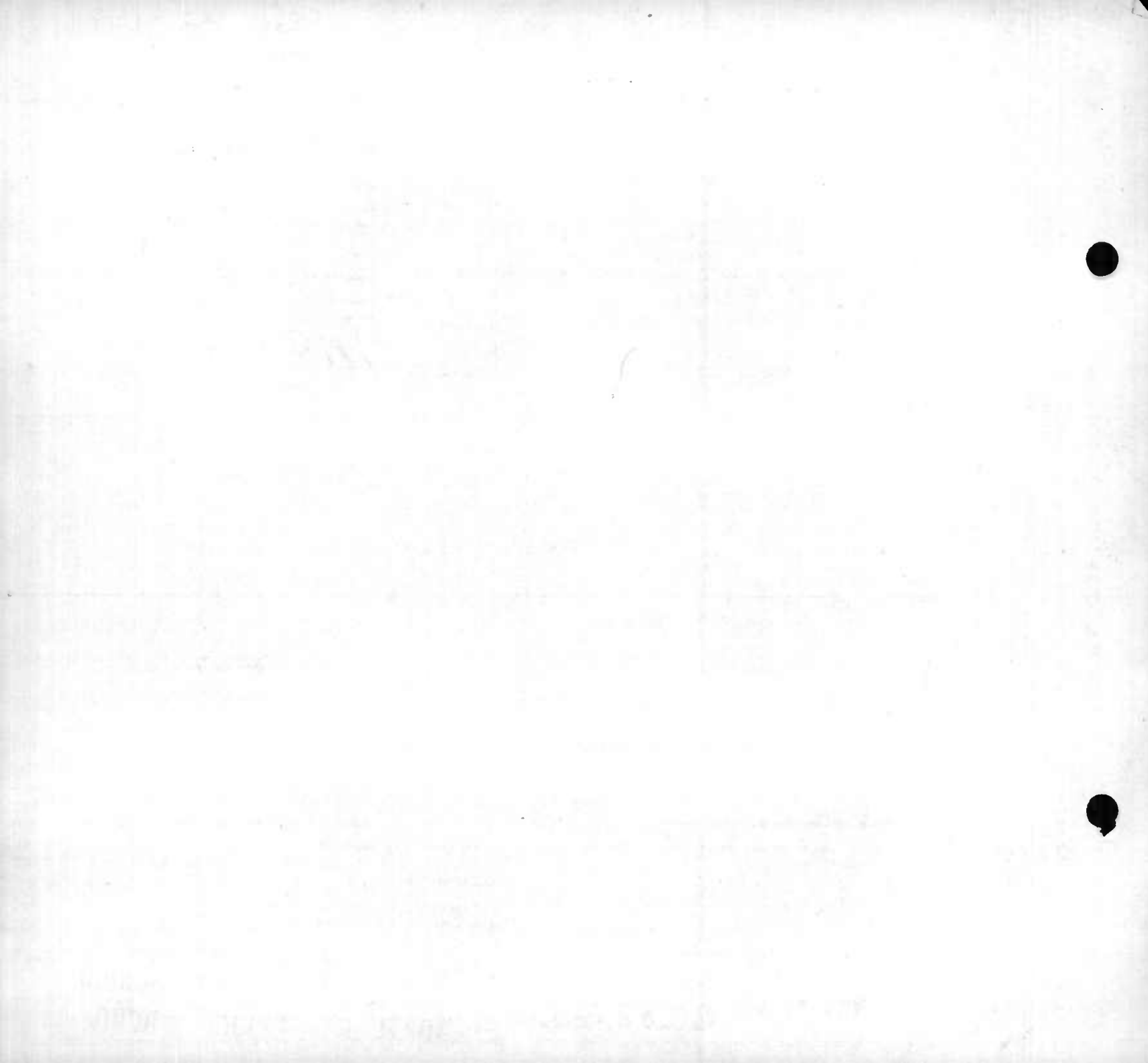
BIRTH NO. 68-21501		68-11859		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11859	
1. NAME OF DECEASED (Type or Print) King, Baby Boy				2. DATE AND HOUR OF DEATH 8 Nov. 11, 1968 800 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Sinai Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) Md. 15-13 C. CITY OR TOWN Baltimore E. STREET AND NUMBER 2621 Rosewood Ave			
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/10/68	
9. AGE (In years lost birthday)		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				13. FATHER'S NAME Charles King			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				14. MOTHER'S MAIDEN NAME Joan Gray		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital chart.				ADDRESS			
18. 776.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Distress Syndrome 11 hrs. Premature birth (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19. DATE OF OPERATION 77315-11				20. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) No				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At <input type="checkbox"/> Work At <input type="checkbox"/>			
22. I certify that (We) (this hospital) attended the deceased from 11/10 533P 1968 to 11/11 800 A 1968, that (I) (We) last saw the deceased alive on 800 A 11/11 1968 and that (my) (We) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23B. DATE SIGNED 11/11/68			
23A. SIGNATURE Douglas S. Kerr M.D.				23C. PHYSICIAN'S NAME (Type) Douglas S. Kerr			
24A. BURIAL CREMATION, REMOVAL (Specify) 11/26/68				24B. DATE 11/26/68			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION			
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968				25B. NAME OF REGISTRAR Robert E. Taylor			
25C. FUNERAL DIRECTOR				25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11860
BIRTH NO. 68-22438		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Baby Boy McClain		2. DATE AND HOUR OF DEATH November 19 1968 11:00 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital of Baltimore		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 3811 Norfolk Ave. #16		
5. SEX Male	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/68	9. AGE (In years lost birthday) 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) U.S.A.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William McClain		14. MOTHER'S MAIDEN NAME Gloria McLain		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
18. 772.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary Hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Subarachnoid Hemorrhage		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Hemorrhage (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19. 760.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 0				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11/18 1968 to 11/19/1968 1968 , that (I) (we) last saw the deceased alive on 11/19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE I. Meyer Heller MD		23B. DATE SIGNED 11/19/1968		23C. PHYSICIAN'S NAME (Type) I. Meyer Heller MD
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/24/68		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State)		25A. DATE RECEIVED NOV 26 1968		
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHO		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11861	
BIRTH NO. 68-19577		68-11861 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BABY BOY HOLMES		2. DATE AND HOUR OF DEATH 11/5/68 1:20 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-02			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1643 N. PAYSON ST.			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/14/68	9. AGE (In years last birthday) 23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME LINDA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT CHART	
18. 038,9 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Streptococcal Infection			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-14-68 1968 to 11-5 1968, that (I) (we) last saw the deceased alive on 11-5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Josefin L.B. de los Santos		23B. DATE SIGNED 11-5-68		23C. PHYSICIAN'S NAME (Type) DR. JOSEFINA L.B. DE LOS SANTOS	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD	

10/11/11

MARYLAND

LINDA

CHART

Emergency Services

10-11-11 11-11-11

11-11-11

Emergency Services

Emergency Services

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11862
BIRTH NO. 68-14387		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) BABY BOY BRAXTON		2. DATE AND HOUR OF DEATH 7-31-68 1:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4 SINAI HOSPITAL OR BALTO		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 15-13 C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER #502 Reisterstown Rd.		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-68	9. AGE (In years last birthday) 49 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EUGENE		
14. MOTHER'S MAIDEN NAME NANCY BOYER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT CHART ADDRESS		
18. 759.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Heart Primary Arter DUE TO, OR AS A CONSEQUENCE OF: (B) Multiple Congenital Anomalies DUE TO, OR AS A CONSEQUENCE OF: (C) Prematurity		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7-31 1968 to 7-31 1968 , that (I) (we) last saw the deceased alive on 7-31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Dr. J. F. de los Santos MD Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) DR. JOSEFINO LB. DE LOS SANTOS MD		23D. ADDRESS Senior Hospital of Balto.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 11/24/68	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
JOHNS HOPKINS MEDICAL SCHOOL				
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR John E. Johnson		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD ADDRESS

GREENE

CHART

MAINT. BOOKS

MAINT. AND

7-31-60

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Library

7-31-60

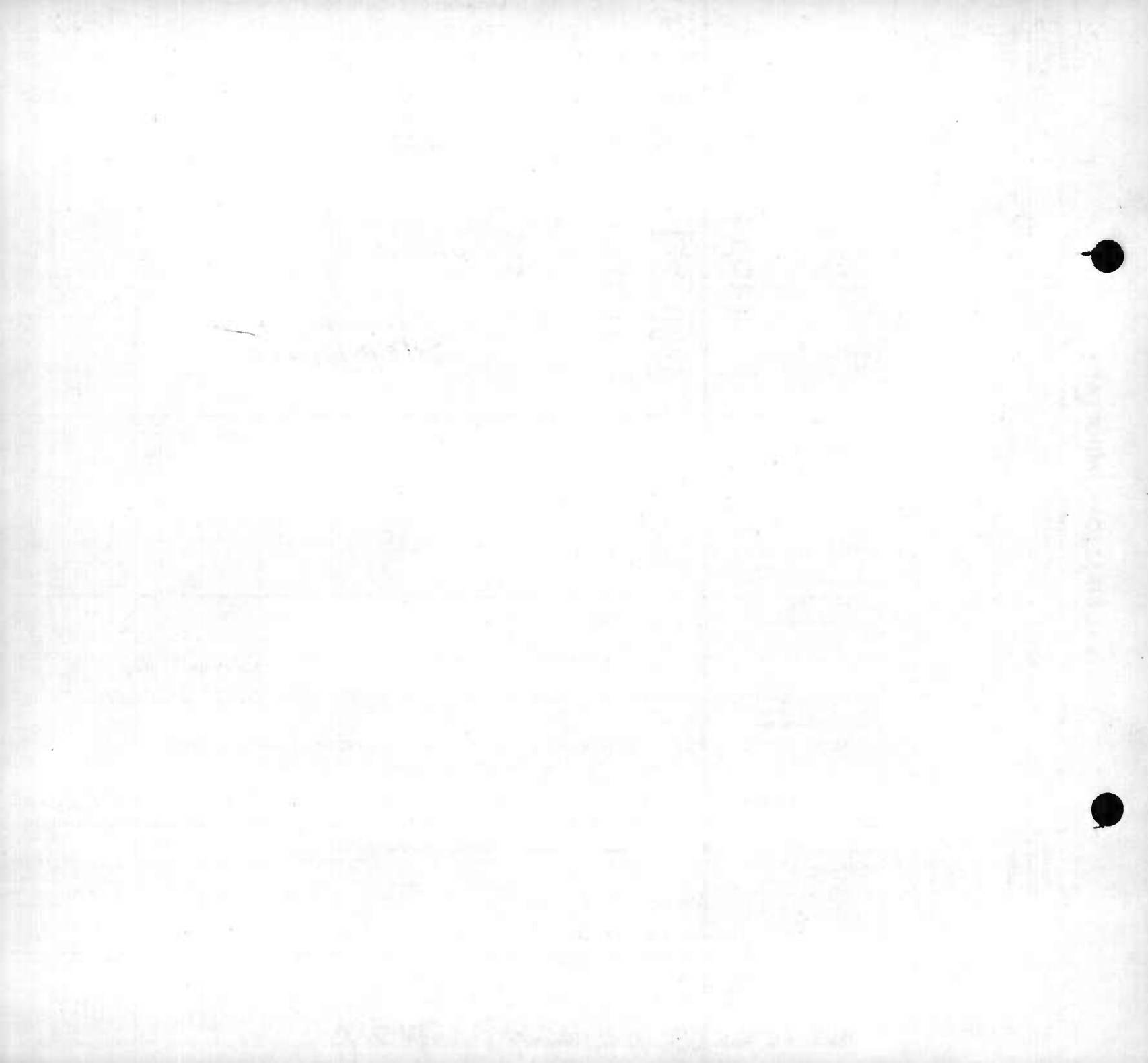
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The book is now in the
Library of the
New York Public Library

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11863</u>	
W-310		68-11863		CERTIFICATE OF DEATH	
BIRTH NO. <u>68-19386</u>					
1. NAME OF DECEASED (Type or Print) <u>Lars Wathne</u>		2. DATE AND HOUR OF DEATH <u>November 3, 1968</u> <u>6:10 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Baltimore, Inc.</u> <u>42</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>	
		E. STREET AND NUMBER <u>233 East University Parkway</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/13/68</u>	9. AGE (In years last birthday) <u>21</u>	If Under 1 Yr. Months: <u>21</u> Days: <u>21</u> Hours: <u>21</u> Min. <u>21</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Magne Wathne</u>		14. MOTHER'S MAIDEN NAME <u>Stephanie</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>008,31</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>septic shock</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>12 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>bacterial enteritis</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>3 days</u>	
(C) <u>—</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>764.0 II</u>		<u>dehydration</u>		<u>24 hours</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>November 2</u> 19 <u>68</u> to <u>November 3</u> 19 <u>68</u> , that (I) (was) last saw the deceased alive on <u>November 3</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death.					
23A. SIGNATURE <u>Barry Green, M.D.</u> DEGREE				23B. DATE SIGNED <u>11/3/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Barry Green, M.D.</u> DEGREE				23D. ADDRESS <u>Sinai Hospital of Baltimore</u> <u>ANATOMY BOARD OF MARYLAND</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11/26/68</u>		24C. NAME OF CEMETERY or CREMATORY	
				24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert S. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>JOHNS HOPKINS MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BOLD</u>	



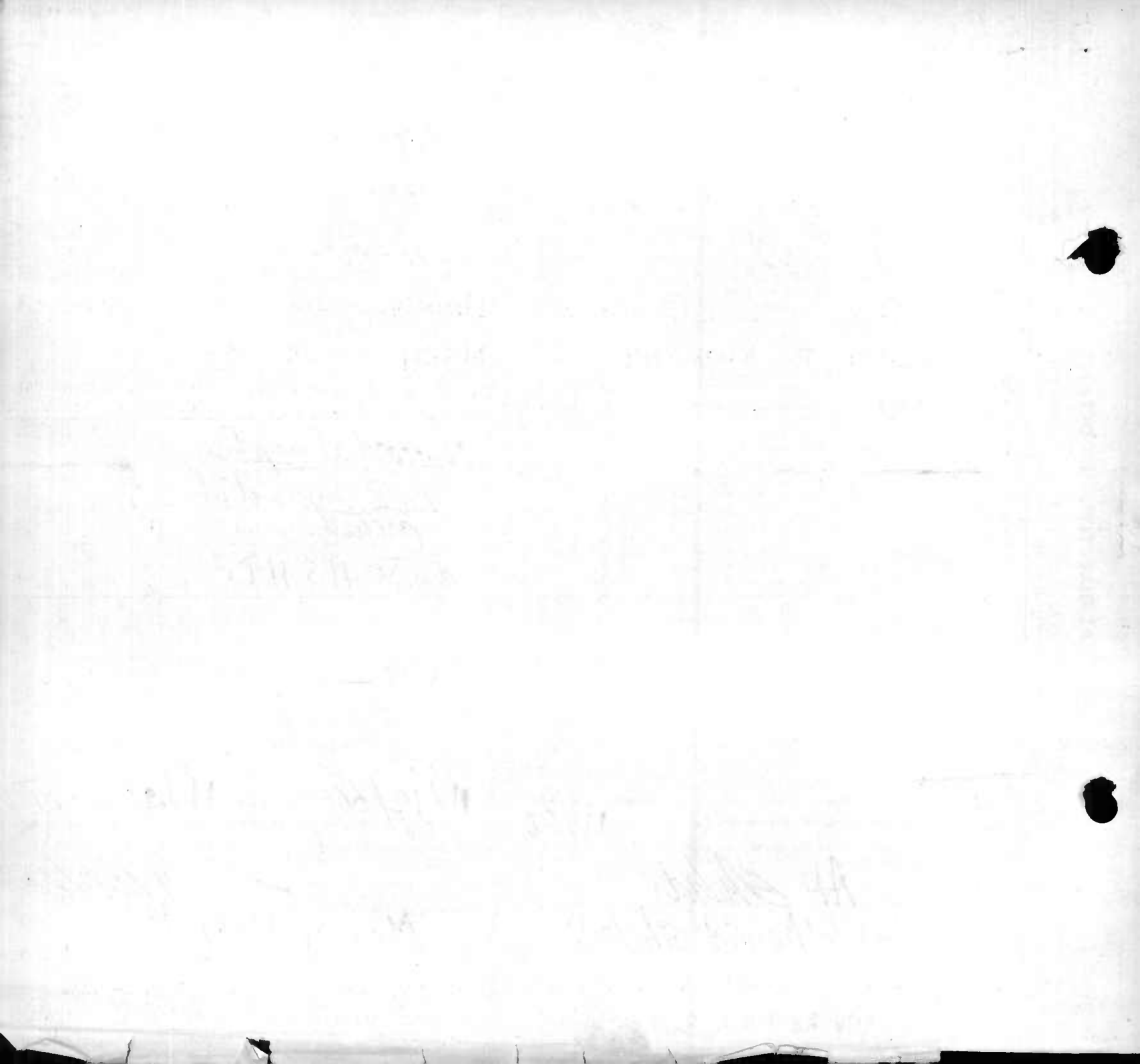
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11864 CERTIFICATE OF DEATH

REG. NO. 68-11864

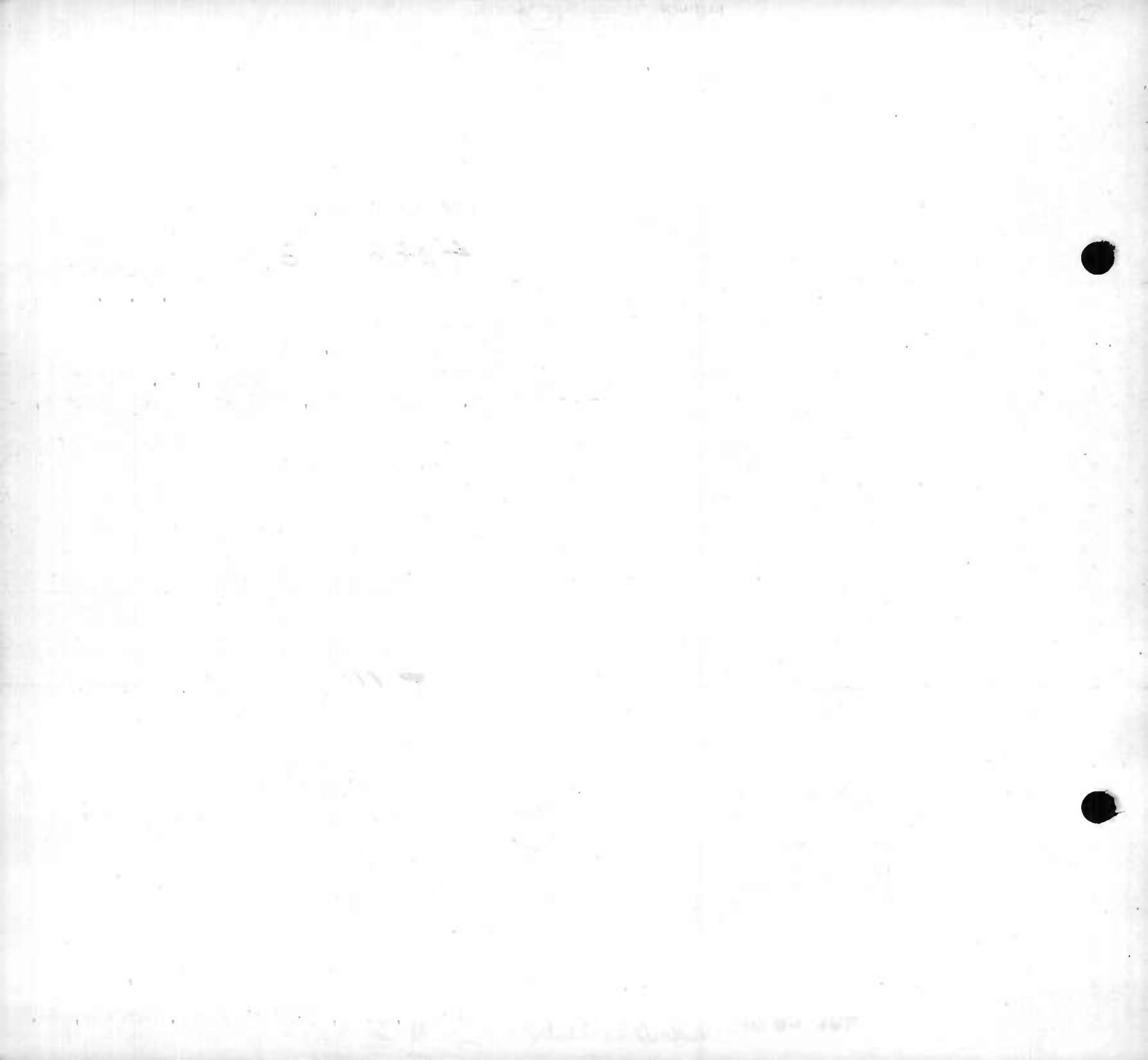
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BROTHER ANSELM, F.S.C.		2. DATE AND HOUR OF DEATH 11-20-68 5¹⁵ A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 66-00	
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL, INC.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BELTSVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS		10B. KIND OF BUSINESS OR INDUSTRY TEACHING		8. DATE OF BIRTH 1-11-86 9. AGE (In years last birthday) 82	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S. AMERICA		13. FATHER'S NAME JOHN T. MURPHY	
14. MOTHER'S MAIDEN NAME MARY ANNE BERGAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-54-9082T	
17. INFORMANT BROTHER HENRY F.S.C. (ANDREW J. LAFFEY)		ADDRESS AMMENDALE NORMAL INST. BELTSVILLE, MD 20705		18. CAUSE OF DEATH 410.9 I Myocardial rupture due to myocardial infarction.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9	
19A. DATE OF OPERATION 420.1 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/19/68 to 11/20 1968 , that (I) (we) last saw the deceased alive on 11/20 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE AM Ghiladi				23B. DATE SIGNED 11/20/68	
23C. PHYSICIAN'S NAME (Type) Abdolhamid Ghiladi				23D. ADDRESS Mercy Hospital	
24A. BURIAL REMOVAL (Specify) BURIAL		24B. DATE 11-23-1968		24C. NAME OF CEMETERY or CREMATORY AMMENDALE CHRISTIAN BRO. CEM	
24D. LOCATION (City, town, or county) (State) BELTSVILLE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR W.W. CHAMBERS CO.		25D. ADDRESS 5801 CLEVELAND AVE RIVERDALE, MD.		150-REV. 1/1/68	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-2600 68-11865 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11865	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Elizabeth J. Boeger ELIZABETH BOEGER		2. DATE AND HOUR OF DEATH 11-22-68 12:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Lutheran Hospital FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MD. 730 ASHBURTON ST. BALTIMORE, MD. 21216			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 53-00 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7500 Riddle Ave.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-86	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Riegel			14. MOTHER'S MAIDEN NAME Isabella V. Kelly		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-56-9694		17. INFORMANT (Nephew) Dundalk, Md. 21222 Mr. Robert Riegel, 2701 Gray Manor Terrace,	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (i) ACUTE MYOCARDIAL INFARCTION (ii) PNEUMONIA (iii) INTESTINAL OBSTRUCTION (c) WITH SEVERE ELECTROLYTE IMBALANCE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-21-1968 to 11-22-1968 , that (I) (we) last saw the deceased alive on 11-22-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pratibha Joshi				23B. DATE SIGNED 11/22/68	
23C. PHYSICIAN'S NAME (Type) PRATIBHA JOSHI		23D. ADDRESS LUTHERAN HOSP OF MD. 730 ASHBURTON ST. BALTO-MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/25/68		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11866
68-11866				CERTIFICATE OF DEATH
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		JOSEPH COLEMAN OTT COLEMAN OTT		2. DATE AND HOUR OF DEATH 11-22-68 2:15 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY MD Baltimore 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION 34 CHURCH HOME & HOSPITAL 100 N. BROADWAY		C. CITY OR TOWN DUNDALK BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 8-5-01		9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beth. Steel Management
11. BIRTHPLACE (State or foreign country) P.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HARVEY OTT		14. MOTHER'S MAIDEN NAME ANNA COLEMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 211,245,780		17. INFORMANT (Wife) Dundalk, Md. 123 Ventnor TERR. MARIE S. OTT
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 796.0 I Respiratory insuff.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 795.0 II				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11-3 19 68 to 11-22 19 68, that (I) (we) last saw the deceased alive on 11-22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE J. F. Mier Jr. M.D.		23B. DATE SIGNED 11-22-68		23C. PHYSICIAN'S NAME (Type) JOSE F. MIER JR. M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/26/68		24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Jesus Cemetery
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. NOV 26 1968		
24F. NAME OF REGISTRAR Robert E. Jackson		24G. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.		

WASHINGTON
123 Vermont Ave

8-2-01

Boat Street - from across P.A.

Anna Coleman

20th Street - from across P.A.

Residence

11-2-01

11-2-01

11-2-01

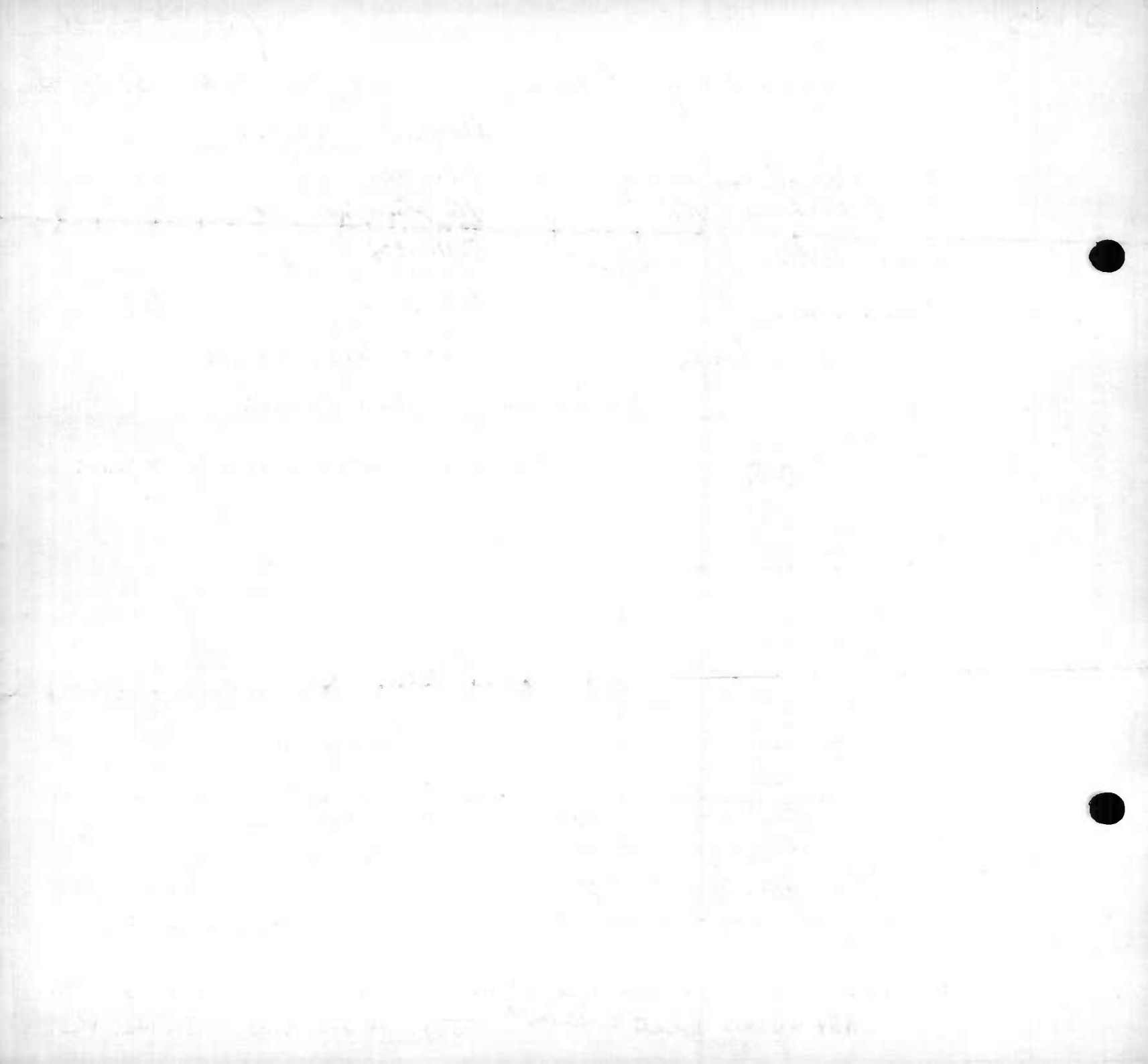
Place in D.C.
Change from 1st

Place in D.C.
Change from 1st

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		68-11867		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		68-11867	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Webster, Mary Frances</i>		2. DATE AND HOUR OF DEATH <i>Nov 20, 1968 5:30 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Harford</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Aberdeen</i>		D. STREET ADDRESS (If rural, give location) <i>418 Lorraine St</i>		62-28	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mount Convalescent Nursing Home</i> <i>3706 Nortonia Rd</i>		(If not in hospital or institution, give street address or location)		5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>5-11-1886</i>		9. AGE (In years last birthday) <i>80</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Snodgrass, James</i>		14. MOTHER'S MAIDEN NAME <i>Sanders, Hannah</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-34-0760A</i>		17. INFORMANT <i>Chart (admission)</i>		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>412.3 I</i> <i>Arteriosclerotic heart disease</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>420.0 II</i>									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>May 11</i> 19 <i>65</i> to <i>Nov. 20</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Nov. 18</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Abraham B. Hurwitz</i> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Nov. 20, 1968</i>					
23C. PHYSICIAN'S NAME (Type) <i>ABRAHAM B. HURWITZ</i>		23D. ADDRESS M.D. <i>7501 Liberty Rd, Baltimore, Md.</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Nov. 22, 1968</i>		24C. NAME of CEMETERY or CREMATORY <i>Emory Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Street, Harford Co. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 26 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Seaburn</i>		25C. FUNERAL DIRECTOR <i>John H. Harkins</i>		ADDRESS <i>Delta, Pa.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11868 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-11868

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ESTHER SCHNEIDER		2. DATE AND HOUR OF DEATH Nov 24, 1968 14:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2755		
FULL NAME OF HOSPITAL OR INSTITUTION MT SINAI NURSING HOME 90			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 4822 WILERN AVE		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPT 12, 1989	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME HYMAN			14. MOTHER'S MAIDEN NAME MINNIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT WALTER SCHNEIDER	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Coronary Thrombosis		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cordes Vascular Disease		(B) DUE TO, OR AS A CONSEQUENCE OF: 15 years	
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 1962 to January 24, 1968 , that (I) (we) last saw the deceased alive on January 24, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cecil Ruoner MD			23B. DATE SIGNED 11-25-68		
23C. PHYSICIAN'S NAME (Type) Cecil Ruoner MD			23D. ADDRESS 6821 NEWTOWN RD BALTO MD		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/26/68		24C. NAME OF CEMETERY or CREMATORY BETH HAMEDRASH HAGDAL	
24D. LOCATION (City, town, or county) (State) BALTO MD					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR SYLVAN S. LEWIS & SON, INC	
25D. ADDRESS 9610 REISTERSTOWN RD					

Central American
Mammals

Central American

Central American
Mammals

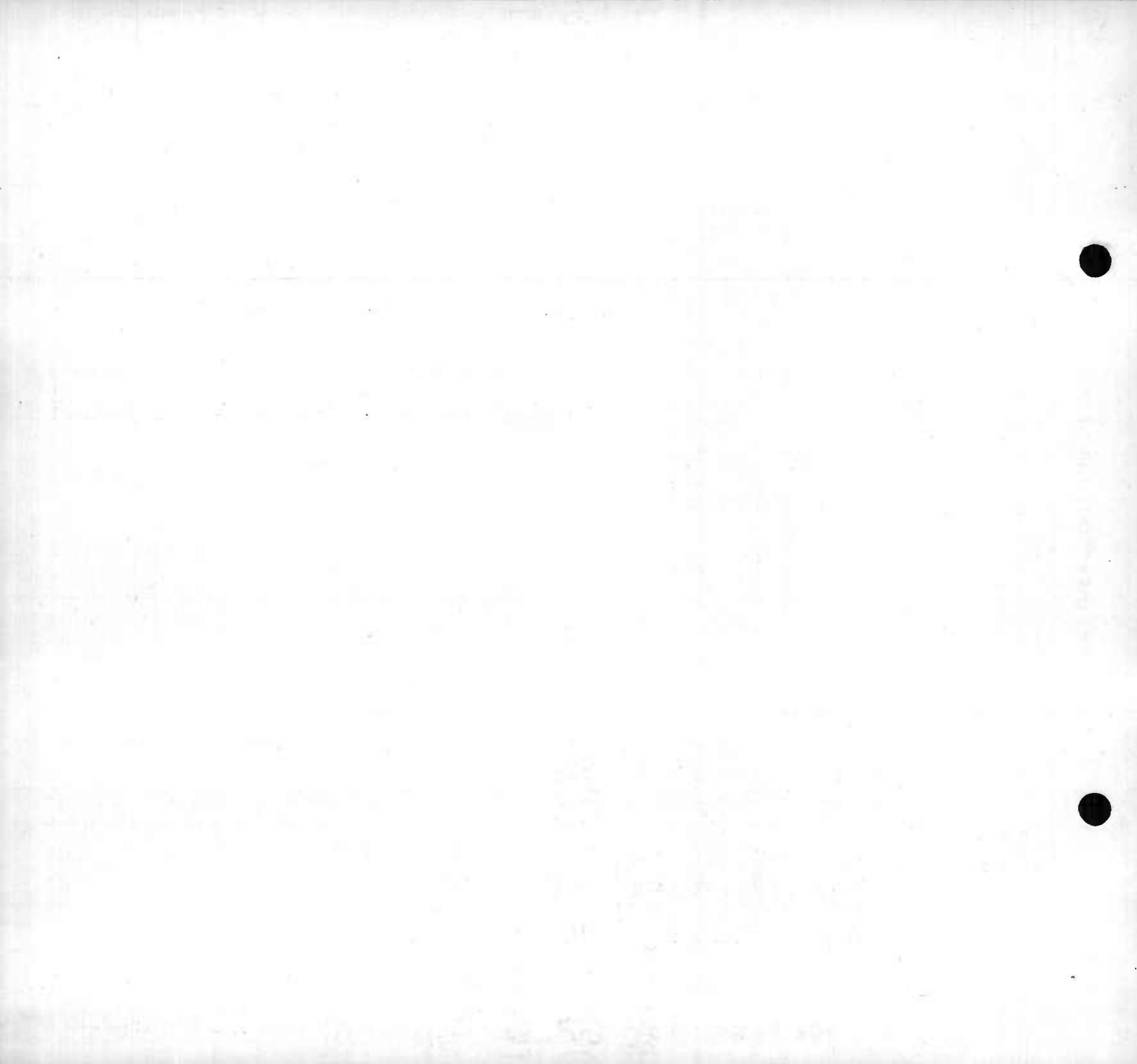
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11869 CERTIFICATE OF DEATH

REG. NO. **68-11869**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Minna Valene		2. DATE AND HOUR OF DEATH Nov. 22, 1968 6:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Baltimore B. COUNTY 11-01		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Siena Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 813 St. Paul	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/93	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10B. KIND OF BUSINESS OR INDUSTRY Food Market		11. BIRTHPLACE (State or foreign country) Lith	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Solomon		14. MOTHER'S MAIDEN NAME Cecilia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-34-5818		17. INFORMANT Mrs Howard Coleman ADDRESS 813 St Paul Street	
18. 410.9 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute MI			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II Rheumatoid Arthritis					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 15, 1968 to Nov 22, 1968 , that (I) (we) last saw the deceased alive on Nov 22, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel Bakal MD				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) DANIEL BAKAL, M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/24/68		24C. NAME OF CEMETERY OR CREMATORY Beth Tiflosh	
24D. LOCATION (City, town, or county) Baltimore		(State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. NOV 28 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc ADDRESS 9610 Resdowntown Rd	



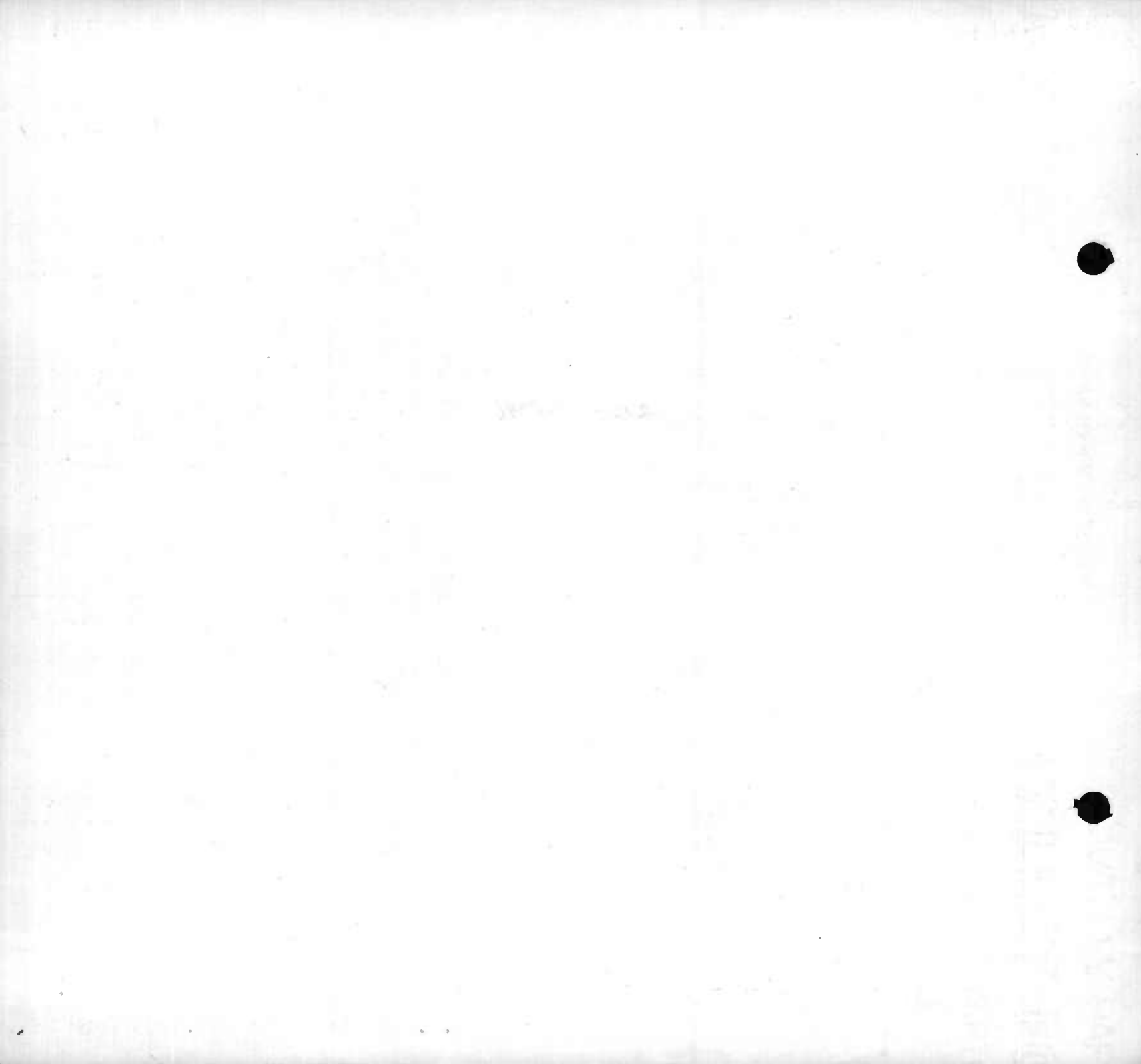
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11870 CERTIFICATE OF DEATH

REG. NO. 68-11870

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MITCHELL, GEORGE W.		2. DATE AND HOUR OF DEATH 11-23-68 - 3:25am	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 13-07	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 500 W. UNIVERSITY PKWY			
5. SEX MALE	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-4-95	9. AGE (In years lost birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE		10B. KIND OF BUSINESS OR INDUSTRY MECHANICAL CONT.		11. BIRTHPLACE (State or foreign country) MARYLAND - U.S.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LLOYD EMERSON MITCHELL			
14. MOTHER'S MAIDEN NAME MARY KERNAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 216-05-8346		17. INFORMANT MRS. MARIE J. MITCHELL			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. H.S.C.V.D. - A.V. Block, left bundle branch, 2 years Cancer of the Sigmoid 12 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30' 20 years 12 years			
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 11-20-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL WALL Tumor		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-13 19 68 to 11-23 19 68 , that (I) (we) last saw the deceased alive on 11-23-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose' Sagbini				23B. DATE SIGNED 11-23-68	
23C. PHYSICIAN'S NAME (Type) Jose' SAGBINI				23D. ADDRESS Sinai Hospital of Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 11-26-68		24C. NAME OF CEMETERY or CREMATORY Lorraine Mausoleum	
24D. LOCATION Baltimore		24E. STATE Md.		24F. CITY, TOWN, OR COUNTY Baltimore	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR H.W. Jenkins & Sons Co.		25C. FUNERAL DIRECTOR 4905 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11871 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11871

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Marie

L.

Batchelder

2. DATE AND HOUR OF DEATH

November 25, 1968

1:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Jefferson Apts.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4 E. 32nd St. Apt. 701

5. SEX

F

6. RACE

W

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

Nov. 2, 1888

9. AGE (In years lost birthday)

80

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF WHAT COUNTRY?

Own Home

13. FATHER'S NAME

Myron Burroughs Dennison

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?

No

16. SOCIAL SECURITY NO.

229-16-0205D

17. INFORMANT

Richard H. James, 1100 Mercantile

ADDRESS

Trust Bldg

18. 410.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

Coronary Occlusion

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Hypertensive Cardiovascular disease

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

immediate

years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from November 1967 to November 10 1968, that (I) (we) last saw the deceased alive on November 10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Percy H. Sutley MD

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

Nov 26, 1968

23C. PHYSICIAN'S NAME (Type)

Dr. Percy H. Sutley

23D. ADDRESS

3005 St. Paul St.

24A. BURIAL CREMATION, REMOVAL (Specify)

Rem. Burial

24B. DATE

11/29/68

24C. NAME OF CEMETERY or CREMATORY

Saturday Cove

24D. LOCATION

Northport,

(City, town, or county)

(State)

Maine

25A. DATE REC'D BY HEALTH DEPT.

NOV 26 1968

25B. NAME OF REGISTRAR

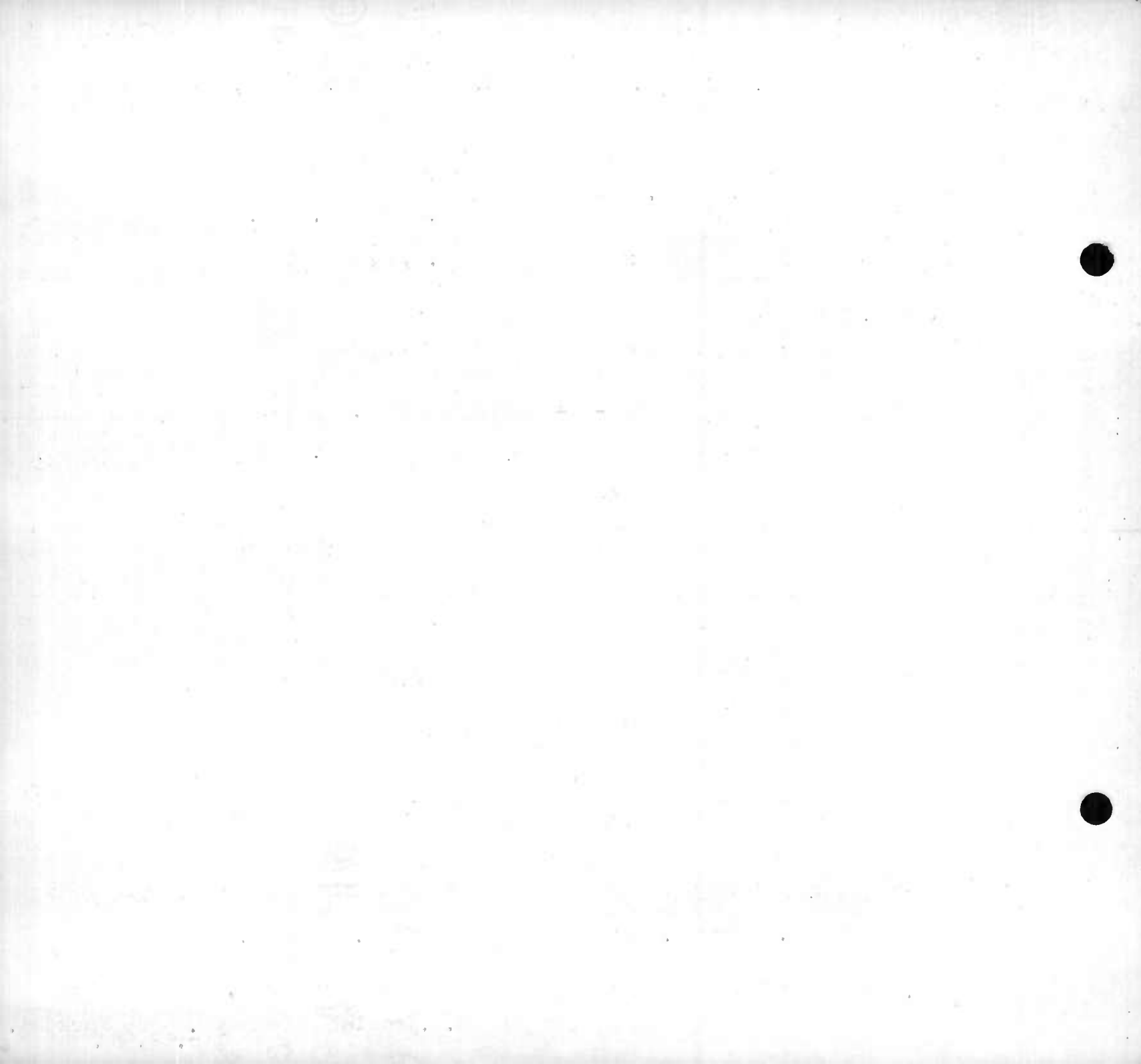
Robert E. Jenkins

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.

ADDRESS

Balto. 12, Md.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11872

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY ROTHROCK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 25, 1968 8:35 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4200 Maine Avenue		3. DATE PRONOUNCED DEAD Month Day Year November 25, 1968 8:35 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1-30-1909		10. AGE (In years last birthday) 59 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		14B. KIND OF BUSINESS OR INDUSTRY None	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-03-5330	
13. FATHER'S NAME Harry C. Rothrock		15. MOTHER'S MAIDEN NAME Ella Frederick	
18. INFORMANT Mrs. W.P. Moorehead		ADDRESS Indiana, Pa.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED November 25, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-30-68	
24C. NAME of CEMETERY or CREMATORY Boalsburg		24D. LOCATION (City, town, or county) (State) Centre County Pa.	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Fickens	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md.	

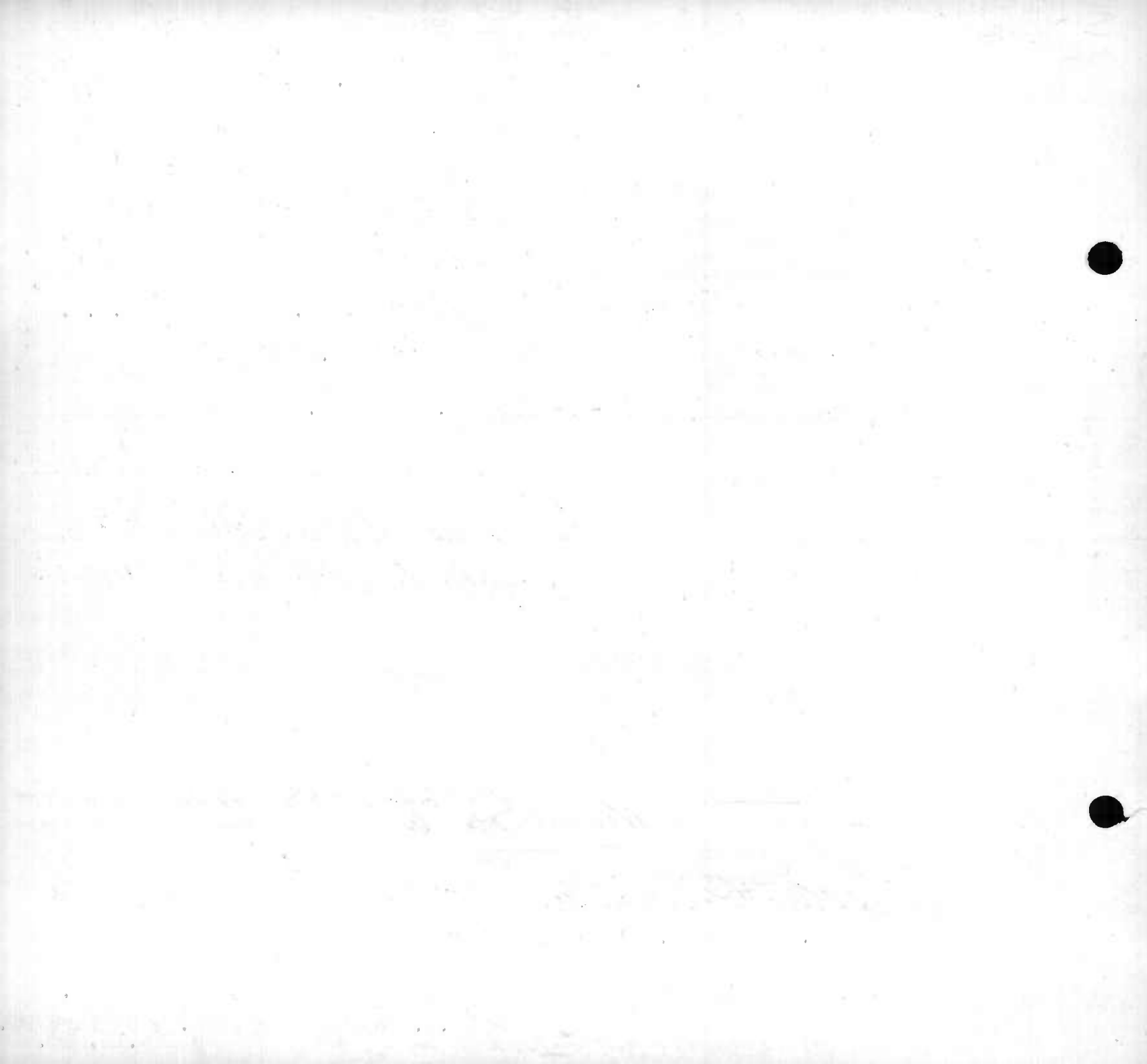
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11873 CERTIFICATE OF DEATH

REG. NO. 68-11873

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Herman I. Stermer		Nov. 25, 1968 5:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 3629 Elkader Road			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore 21218		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3629 Elkader Road		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11/4/1882	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired-Merchant		Paper		Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Isaac Stermer			Sophronia J. Collett		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes WWI		214-03-5330		Mrs. Martha E. Stermer	
			ADDRESS		
			(Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
260X II			Cardio Renal/Vascular Disease 10+ yrs		
			Diabetes Mellitus 10+ yrs		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from October 19 68 to November 23 19 68, that (I) (we) last saw the deceased alive on November 23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Charles F. O'Donnell				11/25/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Charles F. O'Donnell				7501 York Road	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/27/68		Loudon Park	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
		NOV 28 1968		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in the home. If the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11874 CERTIFICATE OF DEATH

REG. NO.

68-11874

1. NAME OF DECEASED (Type or Print) Culler - Mrs. Anna Thrasher		2. DATE AND HOUR OF DEATH 11-25-1968 3:45 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 91 Keswick		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-07 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 700 W. 40th Street - 21211	
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-1891
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk		10B. KIND OF BUSINESS OR INDUSTRY Soc. Security Admin.	9. AGE (In years last birthday) 77
11. BIRTHPLACE (State or foreign country) Jefferson-Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas S. Thrasher		14. MOTHER'S MAIDEN NAME Charlotte Lakin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-18-7964	
17. INFORMANT Rachel C. Gibson		ADDRESS Rt. 1, 700 W. 40th St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 427.01-250.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 434.1 II		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary heart failure (C) Diabetes	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 434.1 II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Days Years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21A. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21C. TIME OF INJURY (APPROX.)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7-27-1968 to 11-25-1968 and that (I) (we) last saw the deceased alive on 11-26-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE RK Gundry		23B. DATE SIGNED 11-25-68	
23C. PHYSICIAN'S NAME (Type) Dr. Richard K. Gundry		23D. ADDRESS 2 W University Pkwy Balto Md 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/68	
24C. NAME OF CEMETERY or CREMATORY St. Paul's Lutheran		24D. LOCATION (City, town, or county) (State) Jefferson, Frederick Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.	

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68-11875 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM H. SCHMITT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 24 68 6:35 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour November 24, 1968 6:35 p.m.	
6. SEX Male	7. RACE White	5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 12-02	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto. 21218	
9. DATE OF BIRTH 7/27/1916	10. AGE (In years lost birthday) 52	E. STREET AND NUMBER 3103 St. Paul St.	
11. BIRTHPLACE (State or foreign country) Norfolk, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		14B. KIND OF BUSINESS OR INDUSTRY Canning	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		17. SOCIAL SECURITY NO. 223-03-5051	
15. MOTHER'S MAIDEN NAME Florence Spalding		18. INFORMANT Sr. M. Damian Schmitt, 3725 Ellerslie Ave	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Nov. 25, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial	24B. DATE 11/29/68	24C. NAME of CEMETERY or CREMATORY Mt. Calvary	24D. LOCATION (City, town, or county) (State) Richmond, Va.
25A. DATE REC'D BY HEALTH DEPT. NOV 26 1968		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.	

68-11875

U.S. CITY HEALTH DEPARTMENT

WALTER H. MOORE

WALTER H. MOORE

WALTER H. MOORE

WALTER H. MOORE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11876 CERTIFICATE OF DEATH

REG. NO. **68-11876**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Joanne Elizabeth Hill		2. DATE AND HOUR OF DEATH 7:30pm 11/22/68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Banks O'Dee Charles Co. B. COUNTY 59-00		M.	
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hospital		C. CITY OR TOWN Tompkinsville, Md		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER		5. SEX F		6. RACE N	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/9/31		9. AGE (In years last birthday) 37	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harry Hill		14. MOTHER'S MARDEN NAME Julia A. Hill	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Julia Hill, Banks-O-Dee, Tompkinsville, Md.	
18. 183.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Ovarian Carcinoma DUE TO, OR AS A CONSEQUENCE OF: (B) Lung Metastases DUE TO, OR AS A CONSEQUENCE OF: (C) Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
175.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/14 19 68 to 11/22 19 68 , that (I) (we) lost saw the deceased olive on 11/22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles J. Hill, M.D.		23B. DATE SIGNED 11-22-68		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS		23E. DEGREE		23F. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 26, 1968		24C. NAME OF CEMETERY or CREMATORY Holy Ghost	
24D. LOCATION (City, town, or county) (State) Issue, Charles Co., Maryland		25A. DATE RECEIVED NOV 27 1968		25B. NAME OF REGISTRAR Robert E. Fisher, MA	
25C. FUNERAL DIRECTOR Arehart Funeral Home Inc., La P		25D. ADDRESS		25E. DEGREE	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11877	
68-11877 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DAUGHTON, CHARLES G.		NOVEMBER 25, 1968 1:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL			A. STATE MARYLAND B. COUNTY A.G.C. 52-00		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN GLEN BURNIE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER 7 CEDAR DR MARLEY HGTS 21061		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04/26/89	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY WHITE COFFEE POT		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN DAUGHTON		14. MOTHER'S MAIDEN NAME SARAH DAUGHTON		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 216-10-2265		17. INFORMANT ADDRESS 5 ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 201X I Tumoral Cachexia			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hodgkin Disease - (Disseminated)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
201X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes-	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 20 19 68 to NOVEMBER 25 19 68, that (I) (we) last saw the deceased alive on NOVEMBER 25 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALEJANDRO MEJIA			23B. DATE SIGNED 11/25/68		23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 27 Nov. 68		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md.	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. LOCATION (City, town, or county) Baltimore, Maryland		24F. LOCATION (City, town, or county) Baltimore, Maryland	



52-85-160
djs

68-11878

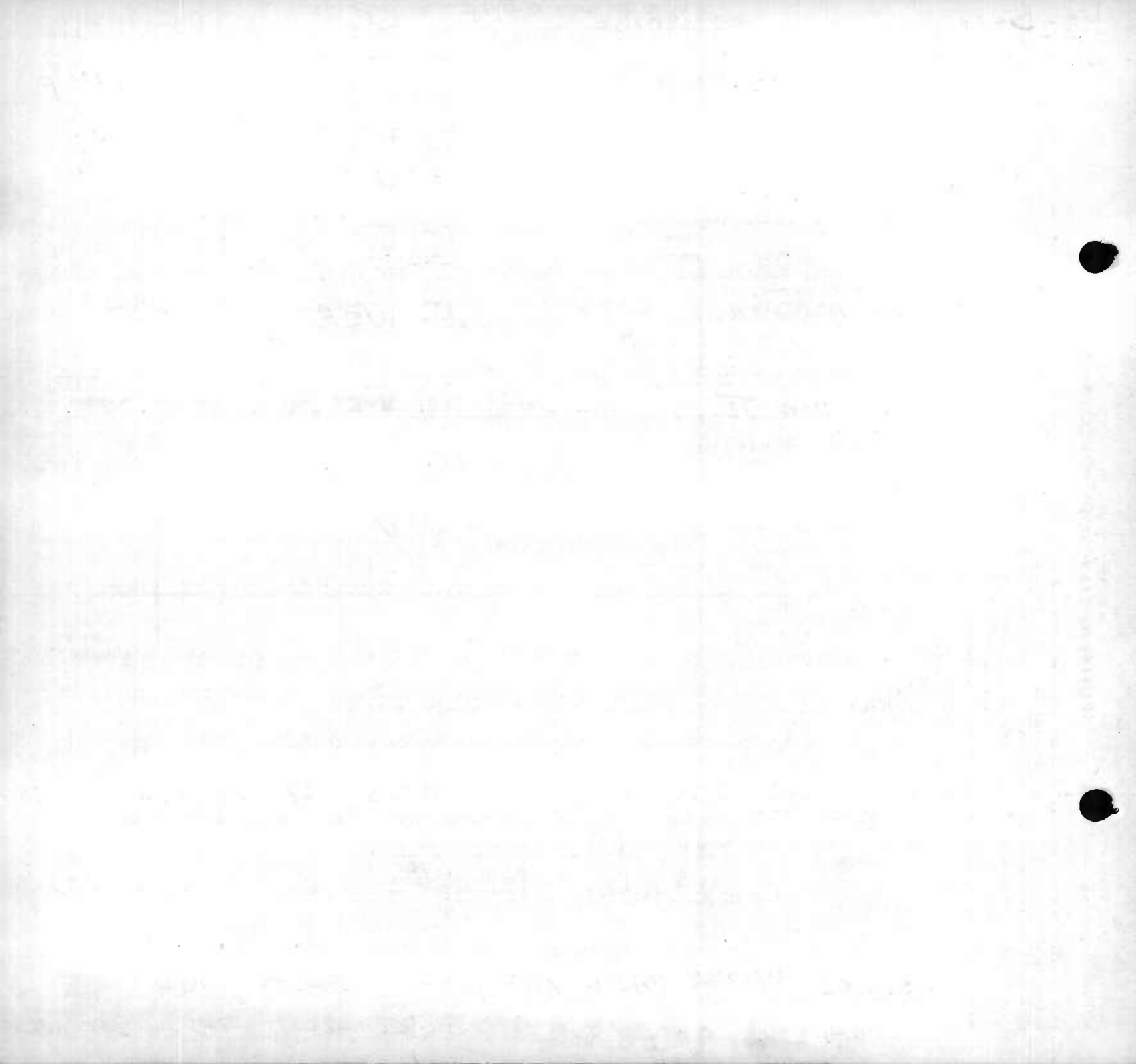
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11878

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HERBERT SCHAFER		11-23-68 610 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND BALTIMORE	
BALTIMORE CITY HOSPITALS 14940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN D. INSIDE CITY LIMITS? ESSEX YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER				51 WILTSHIRE ROAD 21221	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-29-05	63	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
TAX ASSESSOR		CITY		MD	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES WW II		498-32-5998		BCH: RECORDS 4940 EASTERN AVE. BALTO. MD. 21224	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				few hrs	
18.2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-23 19 68 to 11-23 19 68, that (I) (we) last saw the deceased alive on 11-23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
LEE J. CORDOVA M.D.		11/24/68		11/24/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
LEE J. CORDOVA M.D.		BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO. MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11/27/68		BALTO. NAT. CEM	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
		Robert E. Taylor		J. O'CONNELL SONS 300 MACE	

FUNERAL DIRECTOR: IMPORTANT

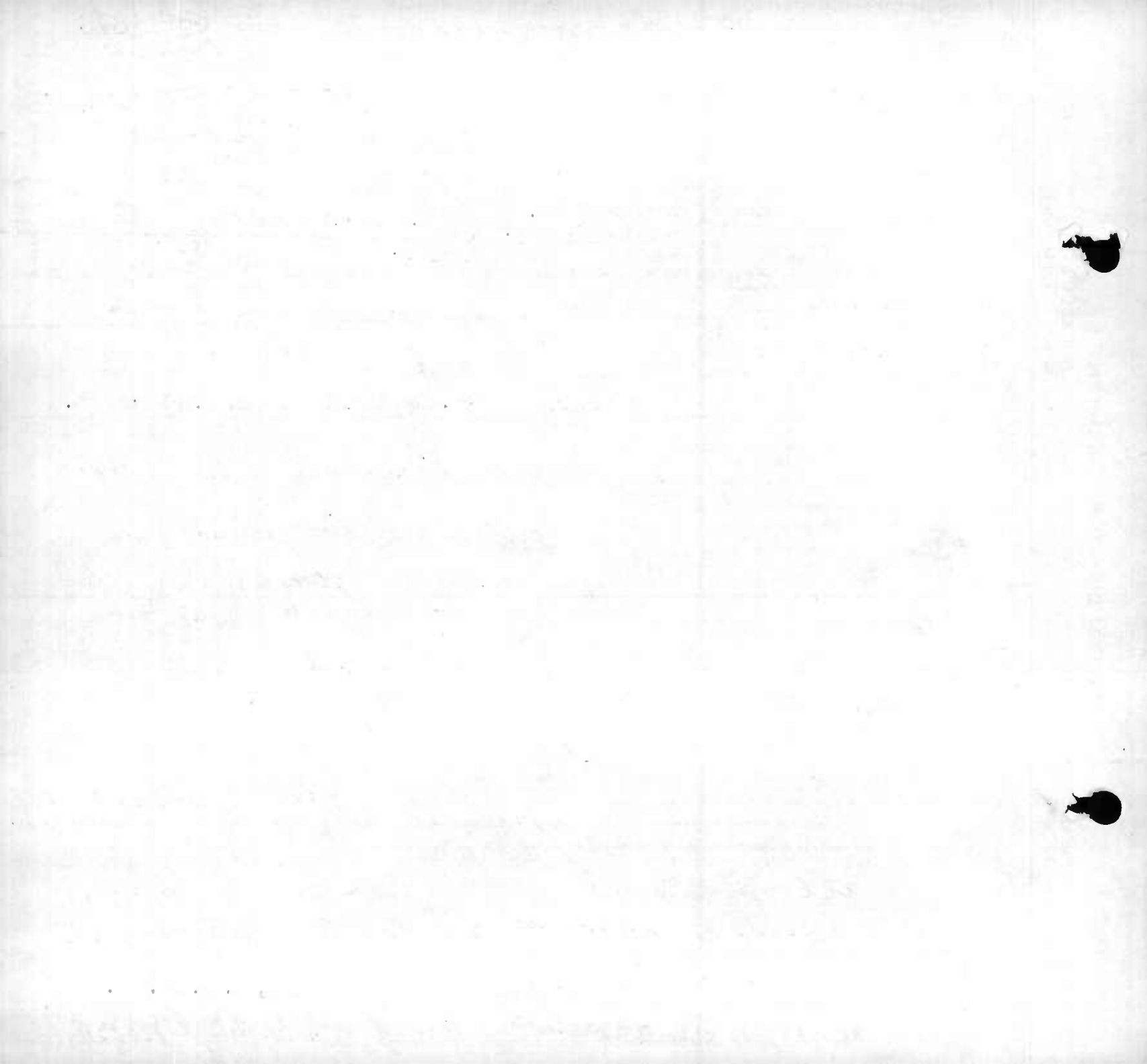
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

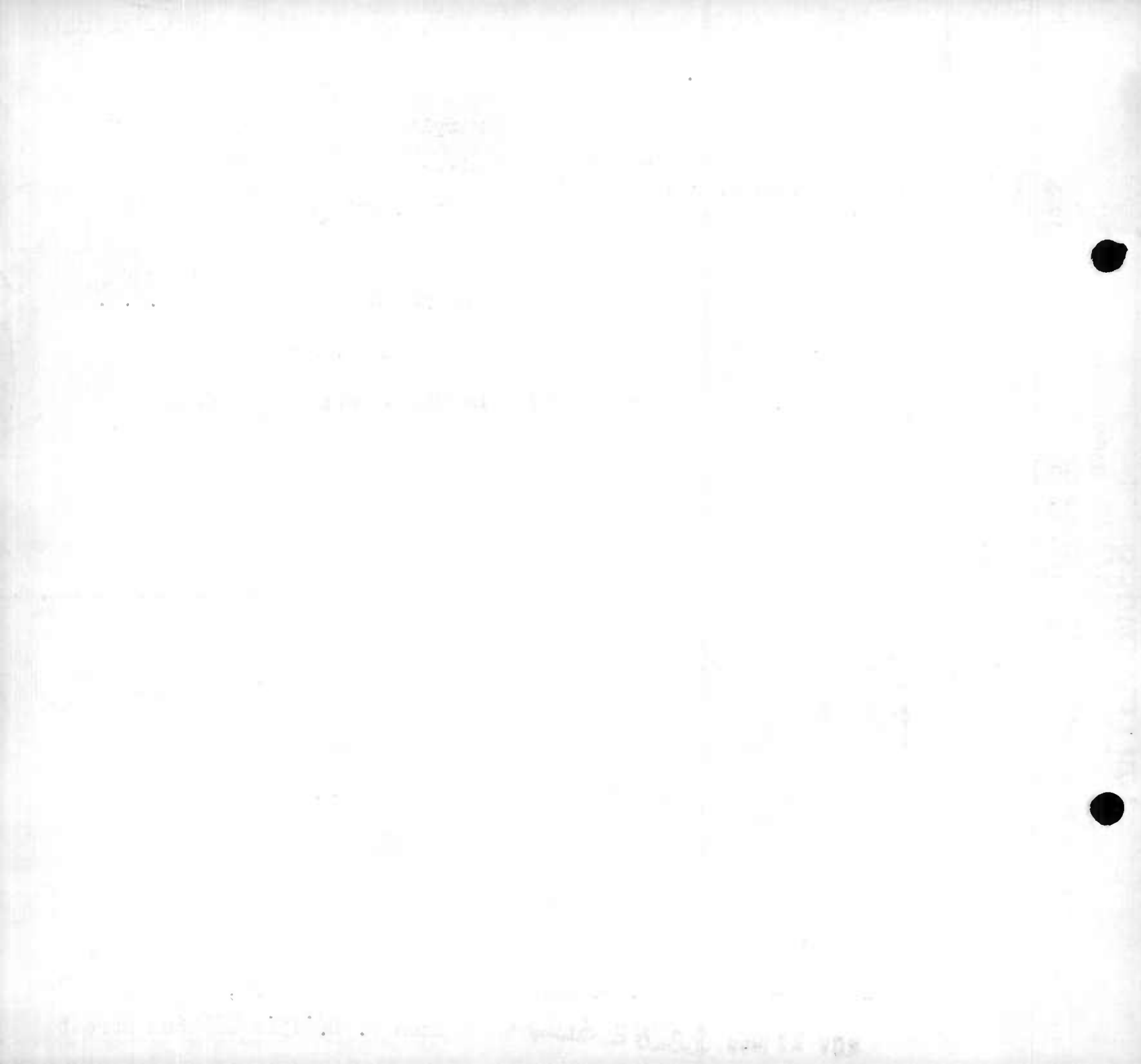
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11879	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 68-11879 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) LUTSCHE, Jennie			2. DATE AND HOUR OF DEATH 11-25-68 12:50 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bolton Hill Nursing & Convalescent Ctr.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 647 E. Clement Street		
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-13-1886	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Karl Schaefer			
14. MOTHER'S MAIDEN NAME Mollie Miller		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-01-9348		17. INFORMANT ADDRESS Mrs. Emmaline Potee 647 E. Clement St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.31-25019 Pneumonia			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 36 hrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.0 II Anterior lobe heart disease			(B) DUE TO, OR AS A CONSEQUENCE OF: yes		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus			(C) DUE TO, OR AS A CONSEQUENCE OF: yes		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/14 1968 to 11/25 1968 , that (I) (we) lost saw the deceased alive on 11/24 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALLAN H. NACHT MD				23B. DATE SIGNED 11/25/68	
23C. PHYSICIAN'S NAME (Type) ALLAN H. NACHT MD				23D. ADDRESS 2 E Pearl St BALTIMORE 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11 27 68		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968			
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR ADDRESS McGee 5 R. W. Hall 130 E. Fort Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11880		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11880	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) DOROTHY V. Cheeks		2. DATE AND HOUR OF DEATH 11/25/68 6:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital Baltimore, Md. 21205		A. STATE Maryland B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2223 N. Pulaski Street 21217			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-9-17	9. AGE (In years lost birthday) 51	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Henderson			14. MOTHER'S MAIDEN NAME Virginia Mays		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 225120475	17. INFORMANT Melvin Cheeks		ADDRESS same
18. 400.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Severe Uremia		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Malignant Hypertension			
		(C) DUE TO			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 445 X II					
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (This hospital) attended the deceased from 11/22 1968 to 11/25 1968 , that (1) (we) last saw the deceased alive on 11/25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marc Lippman M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 11/25/68	
23C. PHYSICIAN'S NAME (Type) MARC LIPPMAN		23D. ADDRESS Johns Hopkins Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-29-68	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR Robert E. Jenkins	25C. FUNERAL DIRECTOR V. R. Bailey ADDRESS Kelson, F. H. 1348 Calhoun Street			

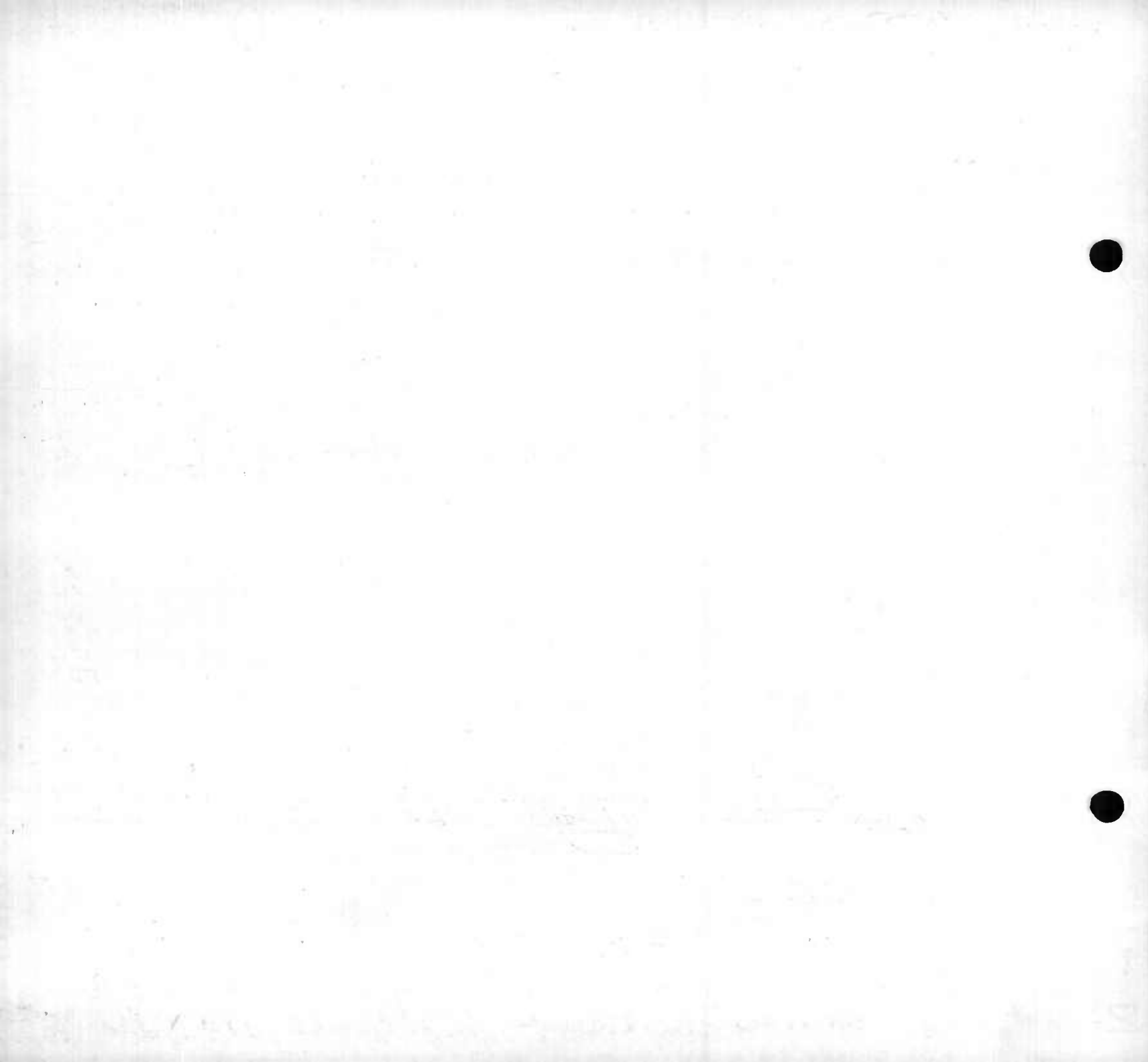


52-24-07
djg

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-320		68-11881		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		68-11881	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>William D. Mattis</u>				2. DATE AND HOUR OF DEATH <u>11/25/68</u> <u>12 20</u> a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Pennsylvania</u> B. COUNTY <u>V-35</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospital</u> <u>4940 EASTERN AVE. BALTO. MD. 21224</u>						C. CITY OR TOWN <u>Shamokin</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/14/46</u>		9. AGE (In years lost birthday) <u>22</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MICHAEL</u>						14. MOTHER'S MAIDEN NAME <u>MARY SMATANA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Embryonal Cell Carcinoma of Testes</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>178 X II</u>						(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>178 X II</u>									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>10/21/68</u> 19 <u>68</u> to <u>11/25</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/25</u> 19 <u>68</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Albert B. Einstein Jr., MD</u> DEGREE						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11/25/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Albert B. Einstein Jr., MD</u> DEGREE						23D. ADDRESS <u>Baltimore City Hospital</u> <u>4940 EASTERN AVE. BALTO. MD. 21224</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>Nov. 27, 1968</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Marys Cemetery Shamokin</u>		24D. LOCATION (City, town, or county) (State) <u>Pa.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 27 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>John Choruka, 114 N. Shamokin St.</u>		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11882 CERTIFICATE OF DEATH

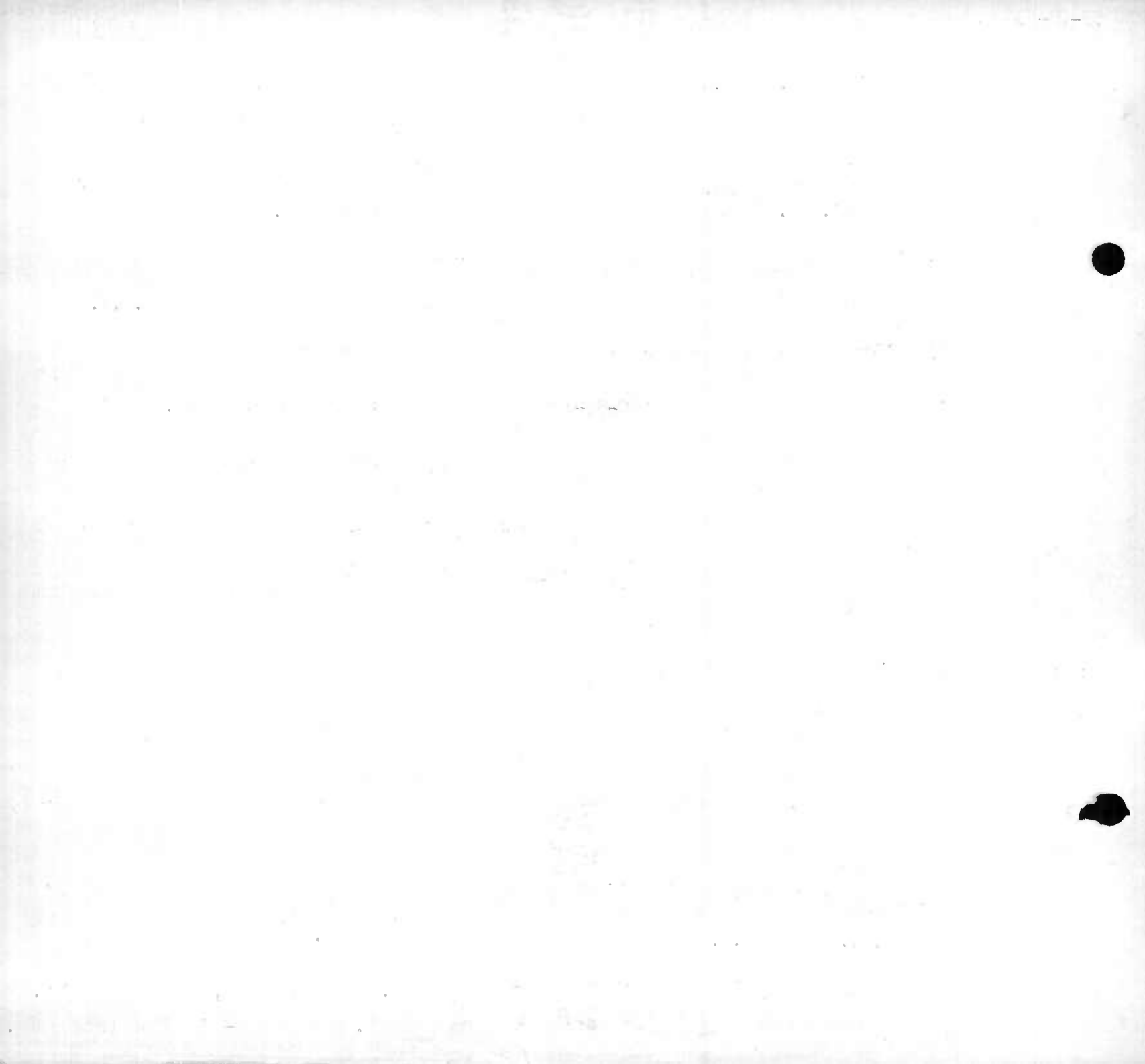
REG. NO. NO

68-11882

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Grace Hobson		11-23-68 11:20 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Caton & Wilkens Avenues Baltimore, Maryland 21229				A. STATE Maryland	
				B. COUNTY Baltimore	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
Baltimore				YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				6 Edmondson Ridge Road	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	Caucasian	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3-16-86	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Maryland		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Israel McKenzie			Day		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
					Mr Robert Ziehm - 6 Edmondson Ridge Rd 21228
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			ACER Cardiac failure & arrhythmia		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Atherosclerotic Heart Disease		
			(C)		
420.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1967 to 23 Nov 1968, that (I) (we) last saw the deceased alive on 23 Nov 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William J Bryson				23 Nov 68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/26/68		Good Shepherd Cemetery	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Howard County - Md		E. S. Mac Nabb		3017 Redbank Rd Balto 28 Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 27 1968		Robert E. Jenkins		E. S. Mac Nabb	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Sarah F. Patton		2. DATE AND HOUR OF DEATH NOV 23, 1968 3:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Ave. Balto. Md. 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-15 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5523 Mattfeldt Ave. 21209		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-86	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Charles Carpenter		14. MOTHER'S MAIDEN NAME Frances Burriss	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-34-7999		17. INFORMANT BCH Records: 4940 Eastern Ave. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLISM ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PERFORATED PEPTIC ULCER FRACTURED HIP			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). E 904.0 II					
19A. DATE OF OPERATION 11-13 & 11-18		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (1) FX HIP (2) PERF. PEPTIC ULCER		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Kitchen		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2124 Spaulding Rd N. H. Ave. Hanes	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 11/12/68 3:35 P.M.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell	
22. I certify that (I) (this hospital) attended the deceased from 11-12 19 68 to 11-23 19 68 , that (I) (we) last saw the deceased alive on 11-23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. E. Powers M.D.				23B. DATE SIGNED 11-23-1968	
23C. PHYSICIAN'S NAME (Type) W. E. Powers M.D.		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Ave. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/27/68	24C. NAME of CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Austin E. Donovan - 3818 Roland Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11884</u>
BIRTH NO. <u>68-11884</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>LEISTER DAVID MCKINLEY</u>		2. DATE AND HOUR OF DEATH <u>11-25-68</u> <u>5:15 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>36 FRANKLIN SQUARE HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1457 WOODALL STREET</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-01</u>	9. AGE (In years last birthday) <u>67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mech.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Chesapeake</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>DAVID LEISTER</u>		
14. MOTHER'S MAIDEN NAME <u>REBECCA MATHIS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>217 03 3065</u>		17. INFORMANT <u>Mrs. Viola Leister comes #4</u>		
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>METASTATIC CA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CA OF EPIGLOTTIS & BRONCHOGENIC CA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. <u>162.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11-11</u> 19 <u>68</u> to <u>11-25</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-25</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>P. Ibarrola</u> <u>MD</u> DEGREE				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <u>PABLO R. IBARROLA MD.</u>				23D. ADDRESS <u>FRANKLIN SQUARE HOSPITAL</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11-27-68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Providence Cemetery Gamber,</u>	24D. LOCATION (City, town, or county) (State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 27 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>	25C. FUNERAL DIRECTOR <u>McCully-130 E. Fort Ave,</u>	ADDRESS <u>21230</u>	

7-7-51

M. W.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11885				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11885	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Naill, William E.</u>				2. DATE AND HOUR OF DEATH <u>11/23/68 1430 P M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 THE JOHNS HOPKINS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CARROLL</u> <u>56-00</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>WESTMINSTER</u>			
				D. STREET ADDRESS (If rural, give location) <u>RT 6</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED</u> (specify)		8. DATE OF BIRTH <u>4-24-10</u>	9. AGE (In years lost birthday) <u>58</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ERNEST BARNES</u>				14. MOTHER'S MAIDEN NAME <u>DENA BYERS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-34-1720</u>		17. INFORMANT <u>Mr. J. Claude Naill</u>		ADDRESS <u>Same As #4.</u>	
18. <u>441.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>451X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>Dissecting aneurysm</u> (B) <u>Aortic + hypertension</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>9 Days</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>11/22</u> <u>1968</u> to <u>11/23</u> <u>1968</u> , that (2) (we) last saw the deceased alive on <u>11/23/</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Marc Lippman</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>11/23/68</u>			
23C. PHYSICIAN'S NAME (Type) <u>MARC LIPPMAN</u> M.D.				23D. ADDRESS <u>Johns Hopkins</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/26/1968</u>		24C. NAME of CEMETERY or CREMATORY <u>Taylorville</u>		24D. LOCATION (City, town, or county) (State) <u>Taylorville, Carroll, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 27 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>C. M. Waltz</u>		ADDRESS <u>Box 241, Sykesville, Md.</u>	



68-11836 BALTIMORE CITY HEALTH DEPARTMENT

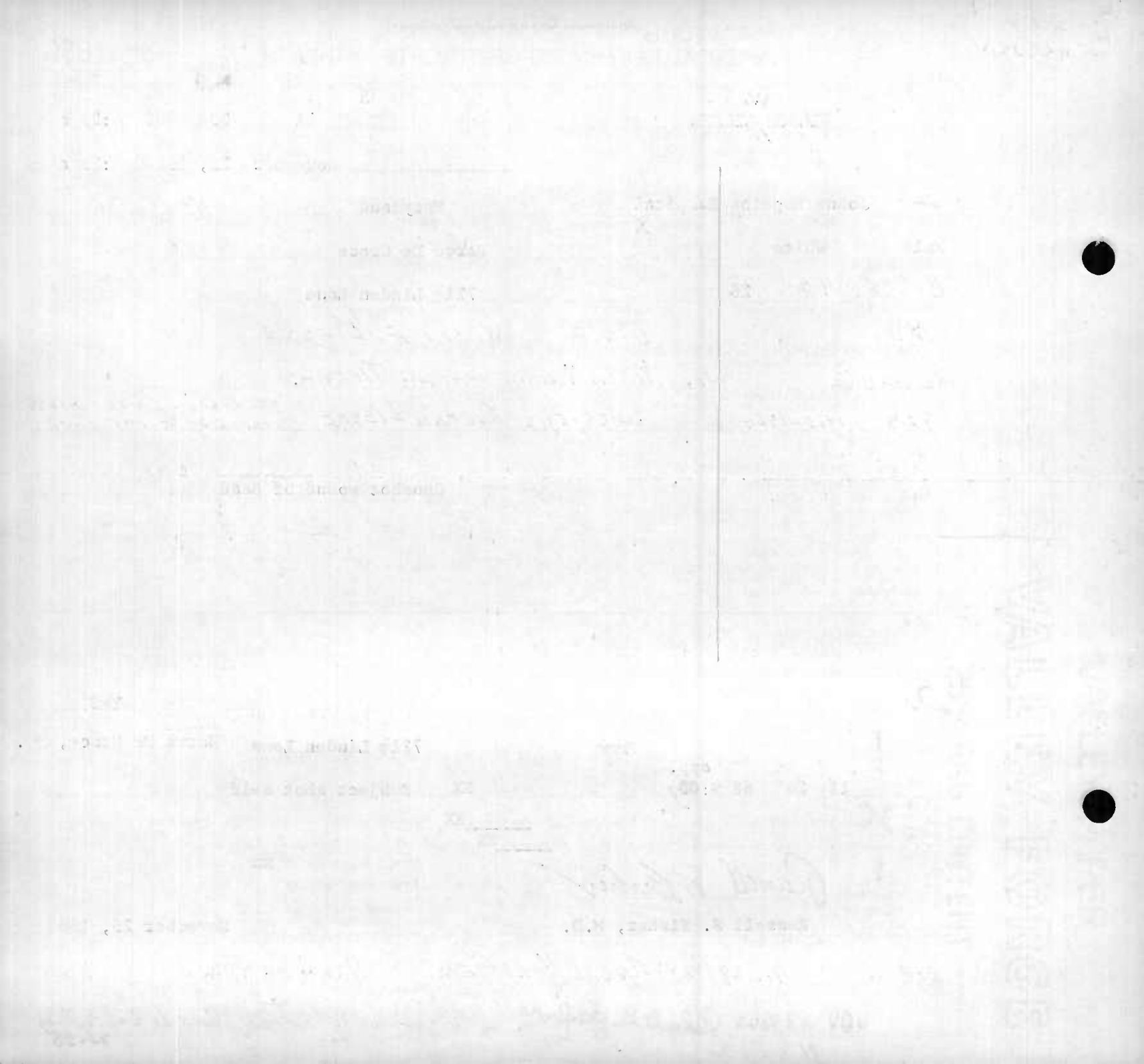
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NC

68-11886

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILSON LIESKE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 11 Day 25 Year 68 Hour 4:29 a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month November Day 25 Year 1968 Hour 4:29 a M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY HARFORD	
7. RACE White		C. CITY OR TOWN Harve De Grace	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH OCT. 28, 1942		E. STREET AND NUMBER 721 1/2 Linden Lane	
10. AGE (In years lost birthday) 26		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILSON F. LIESKE	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		14B. KIND OF BUSINESS OR INDUSTRY ABER. PRIVING GARAGE	
15. MOTHER'S MAIDEN NAME SARAH THOMAS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES 1960-1964	
17. SOCIAL SECURITY NO. 213-29-5713		18. INFORMANT LOU ANN LIESKE	
19. CAUSE OF DEATH E965X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E981X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 721 1/2 Linden Lane Harve De Grace, Md.	
22D. TIME (Month) (Day) (Year) (Hour) (Appr.) 11 24 68 9:00pm		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject shot self		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 25, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Nov. 27, 1968	
24C. NAME OF CEMETERY or CREMATORY ANGEL HILL CEM.		24D. LOCATION (City, town, or county) (State) HARVE DE GRACE MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR R. Madison Mitchell		ADDRESS Harve De Grace Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11887

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11887

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EMMA O'NEILL

2. DATE AND HOUR OF DEATH

NOV. 25 1968 10:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

North Charles General Hospital
49

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

2004 Denbury Drive

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

4-14-84

9. AGE (In years last birthday)

84

Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Jacobs Franks

14. MOTHER'S MAIDEN NAME

Lorisa Schitzer

15. Was Deceased Ever in U. S. Armed Forces? (Yes or no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Hosp. Chart

18. 412.24-1250.9

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF,

Cerebro-vascular accident 7 days
Hypertensive arteriosclerotic
cardio-vascular disease

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Diabetes Mellitus

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 20 1968 to Nov. 25 1968, that (I) (we) last saw the deceased alive on Nov. 25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

L. Tanguilig M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

Nov. 25, 1968

23C. PHYSICIAN'S NAME (Type)

L. TANGUILIG M.D.

23D. ADDRESS

N. Charles General Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

11/28/68

ANNUNCIATION CEMETERY

SHENANDOAH PA

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 27 1968

Robert E. Tanguilig

ULRICH FUNERAL HOME - 4210 BELT RD
FOR ORAUITZ FUNERAL HOME.
SHENANDOAH PA

W. H. Cannon
Hospital

F W

Housewife
Kento Frank

2004 Broadway

4-14-84

Penicillin
Lentils
Thyroid

Curbs - wooden
Hypertension -
Hypertension -

Resistant

Mr 22
Mr 28

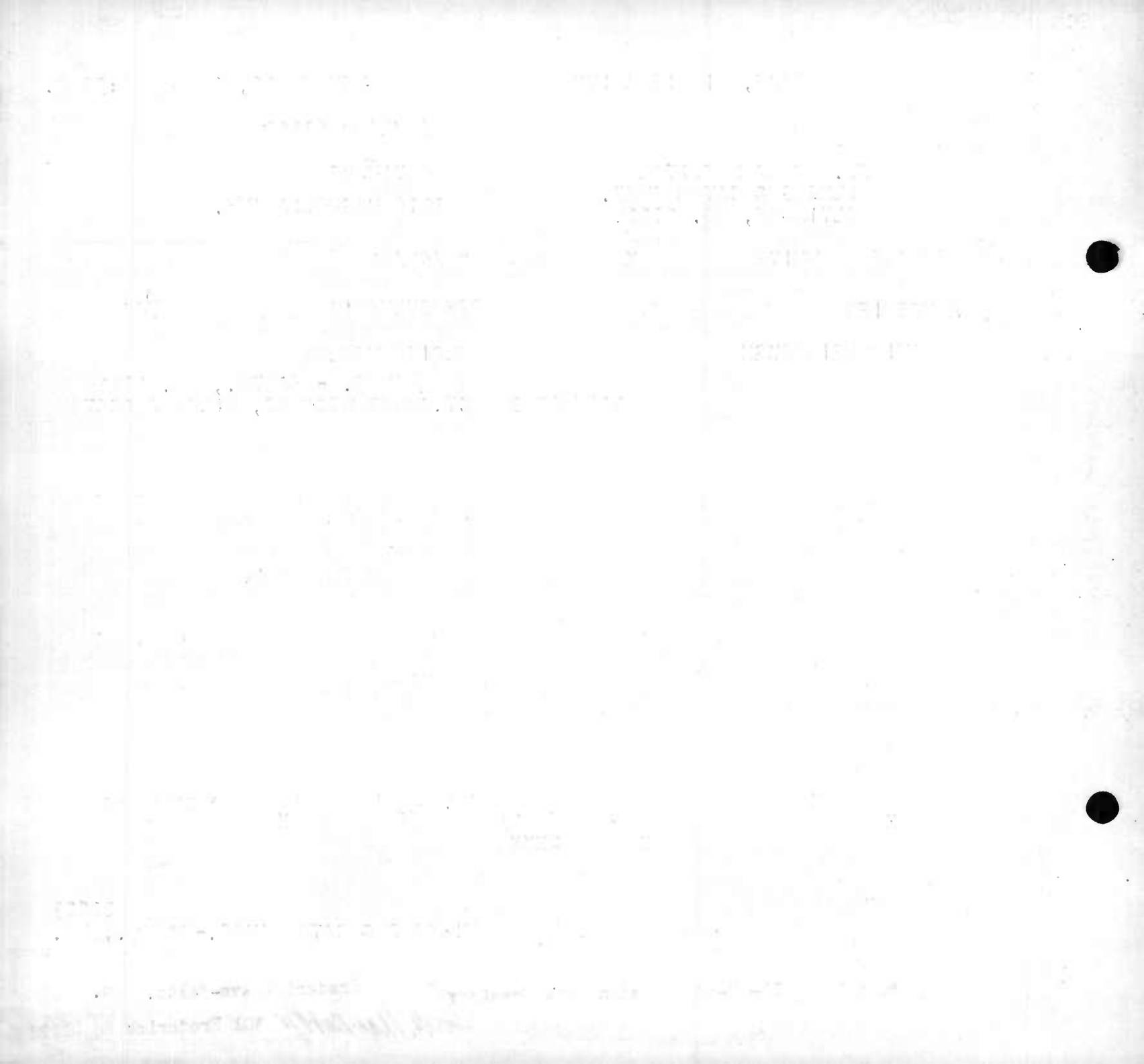
Mr 22
Mr 28
Mr 28
Mr 28

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 68-11888

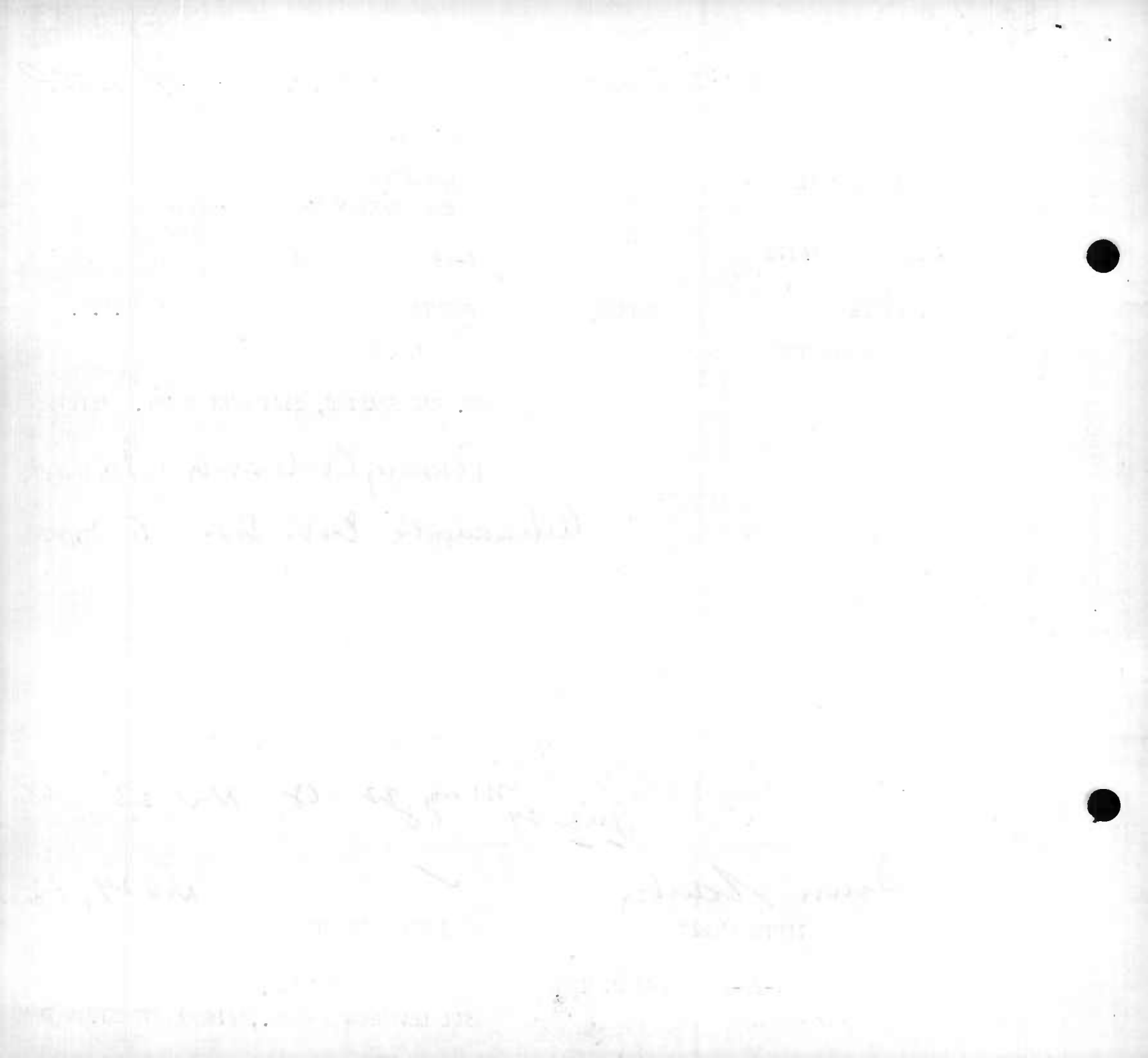
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MEESE, MINNIE EDITH		NOVEMBER 23, 1968 5:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229			A. STATE MARYLAND 21227 B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1716 MAGNOLIA AVE.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/07/82	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME DAVID HEINBAUGH		
14. MOTHER'S MAIDEN NAME ELSIE WHEELER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service)		
16. SOCIAL SECURITY NO. 214504293			17. INFORMANT AVES. - BALTO., MD. 21229 ST. AGNES RECORDS, WILKENS & CATON		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE Acute Congestive Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) Intestinal Obstruction Hemiplegia					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 450.0 II Hemiplegia					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 4 19 68 to NOVEMBER 23 19 68, that (X) (we) last saw the deceased alive on NOVEMBER 23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Romualdo B. Pator, M.D.				23B. DATE SIGNED 11-23-68	
23C. PHYSICIAN'S NAME (Type) Romualdo B. Pator, M.D.				23D. ADDRESS WILKENS & CATON AVES. - BALTO., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-27-68		24C. NAME OF CEMETERY or CREMATORY London Park Cemetery	
24D. LOCATION Frederick Ave - Balto. Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR 301 Frederick Rd 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

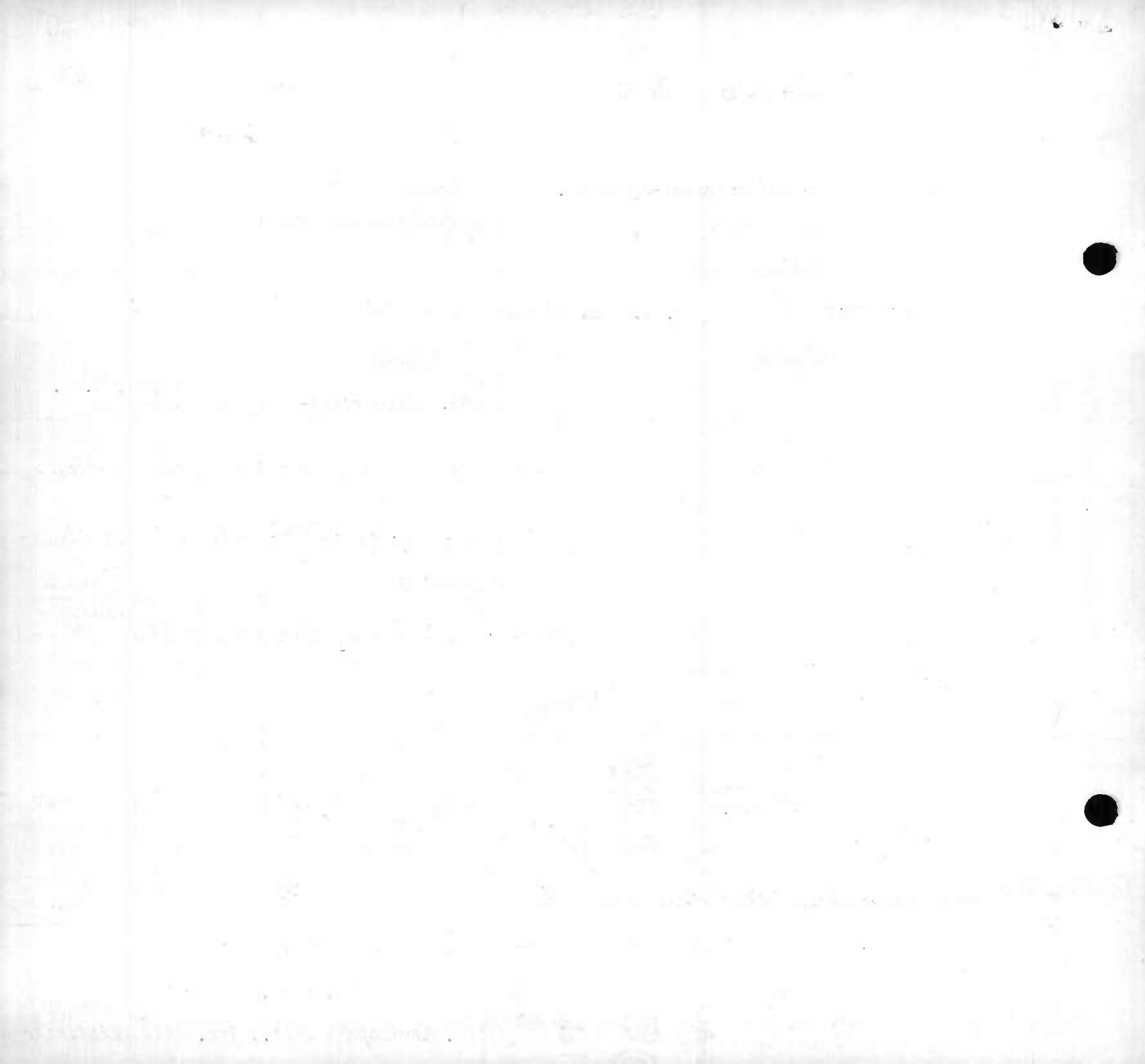
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11889</u>
68-11889				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MORRIS SHAPIRO</u>		
2. DATE AND HOUR OF DEATH <u>November 23/68 1025 P.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u> <u>12</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>2</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2864 OAKLEY AVENUE #21215</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-1900</u>	9. AGE (In years last birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>GROCER</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>AARON SHAPIRO</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. RAE SHAPIRO, 2864 OAKLEY AVE. #21215</u>
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Occlusion Immed.</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Anterolateral E. V. Dis. 6 mo.</u> (B) _____ (C) _____		
19. <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>May 22 1968</u> to <u>Nov 23 1968</u> , that (I) (we) lost saw the deceased alive on <u>June 24 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Irvin Sauber</u>		23B. DATE SIGNED <u>Nov 24, 68</u>		23C. PHYSICIAN'S NAME (Type) <u>IRVIN SAUBER</u>
23D. ADDRESS <u>6905 PARK HEIGHTS AVENUE</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-25-68</u>		24C. NAME of CEMETERY or CREMATORY <u>SHAAREI ZION</u>
24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 27 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11890
BIRTH NO.		68-11890		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Jacob Ecker</u>			2. DATE AND HOUR OF DEATH <u>11/24/68</u> <u>9:50 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital-of Balto.</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>N.Y.</u> B. COUNTY <u>V-29</u>		
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>80</u> 9. AGE (In years last birthday) <u>80</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee</u>			11. BIRTHPLACE (State or foreign country) <u>New York</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>U. S. Post Office</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Mrs. Helen Ecker-3366 Decatur Avenue</u>			ADDRESS <u>Bronx, N. Y.</u>		
18. <u>410.91-250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Ventricular Fibrillation</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 minutes</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> <u>10 days</u>		
			(B) <u>ASCVD</u> <u>3 years</u>		
			(C) <u>Pulmonary Edema; diabetes mellitus</u> <u>10 days + 20 years</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> 19 <u>68</u> to <u>11/24</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/24</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanford H. Malinow MD</u>				23B. DATE SIGNED <u>11/24/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>STANFORD H. MALINOW MD</u>				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>11/24/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sharon Gardens</u>	
24D. LOCATION (City, town, or county) <u>Valhalla, New York</u>		24E. STATE (State) <u>New York</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 27 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>2 Sol. Levinson & Bros., Inc. 6010 REisterstown</u>	



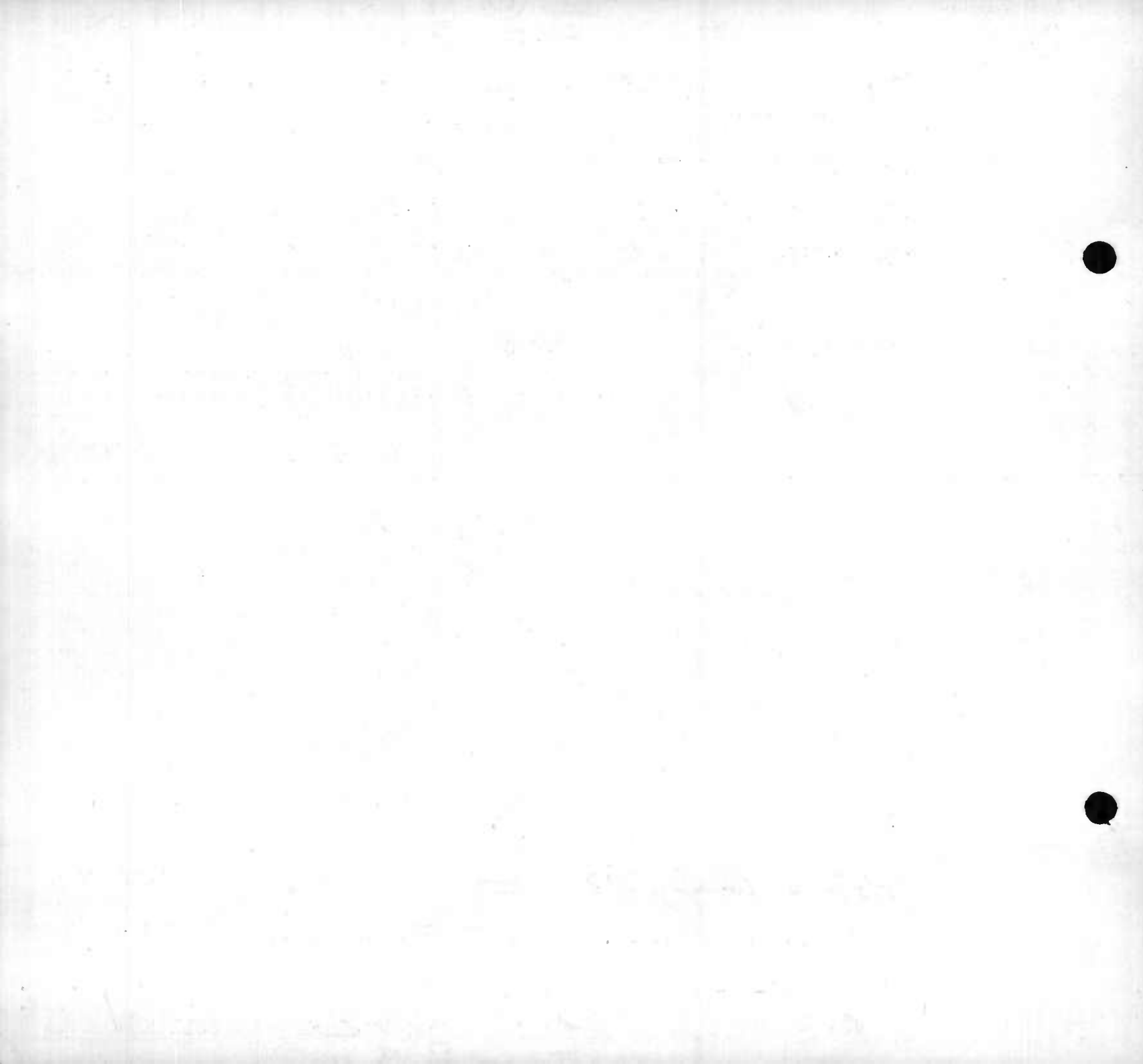
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11891 CERTIFICATE OF DEATH

REG. NO. 68-11891

BIRTH NO.		1. NAME OF DECEASED ALICE PHOEBE MOYER		2. DATE AND HOUR OF DEATH NOVEMBER 26, 1968 6:15A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL <small>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small> WILKENS AND CATON AVENUES BALTIMORE MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 5513 ASHBOURNE ROAD	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02 25 86	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ADDISON CLARK		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213 14 2486		17. INFORMANT RECORDS BALTIMORE MD 21229 ST AGNES HSOPITAL WILKENS & CATON AVE	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis (B) ASCVD, marked DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day > 5 years	
19. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		GI Bleeding		1 day	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 25, 1968 to NOVEMBER 26, 1968 , that (X) (we) last saw the deceased alive on NOVEMBER 26, 1968 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did not) view the body after death.					
23A. SIGNATURE Morton B. Blumberg M.D.		23B. DATE SIGNED 11/26/68		23C. PHYSICIAN'S NAME (Type) MORTON B. BLUMBERG M.D.	
23D. ADDRESS BALTIMORE MD 21229		23E. STREET AND NUMBER ST AGNES HOSPITAL WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-29-68		24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE CEMETERY	
24D. LOCATION (City, town, or county) WASH. BLVD & DORSEY RD. MD.		(State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR WEBER FUNERAL HOME 5311 EDMONDSON	



m-250

68-11892 BALTIMORE CITY HEALTH DEPARTMENT

68-11892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

EMMA MASON

2. DATE OF DEATH

Known ☒ Estimated ☐

Month Day Year

Hour

1:20 p

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

3. DATE PRONOUNCED DEAD

Month Day Year

November 26, 1968

1:20 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

Female

7. RACE

Colored

B. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

9. DATE OF BIRTH

2-25-1896

10. AGE (In years last birthday)

72

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1375 N. Gilmore St.

11. BIRTHPLACE (State or foreign country)

M.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Fannie

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Bessie Holmes 2841 W. North Ave.

19. E812.1

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Injuries
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Gilmore & Baker St.

15-01

22D. TIME OF INJURY (APPROX.)

11 26 68 12:01

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Passenger thrown out of car into pole,

after auto-auto collision

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/27/68

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-30-68

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Pk.

24D. LOCATION (City, town, or county)

Arbutus, Md.

(State)

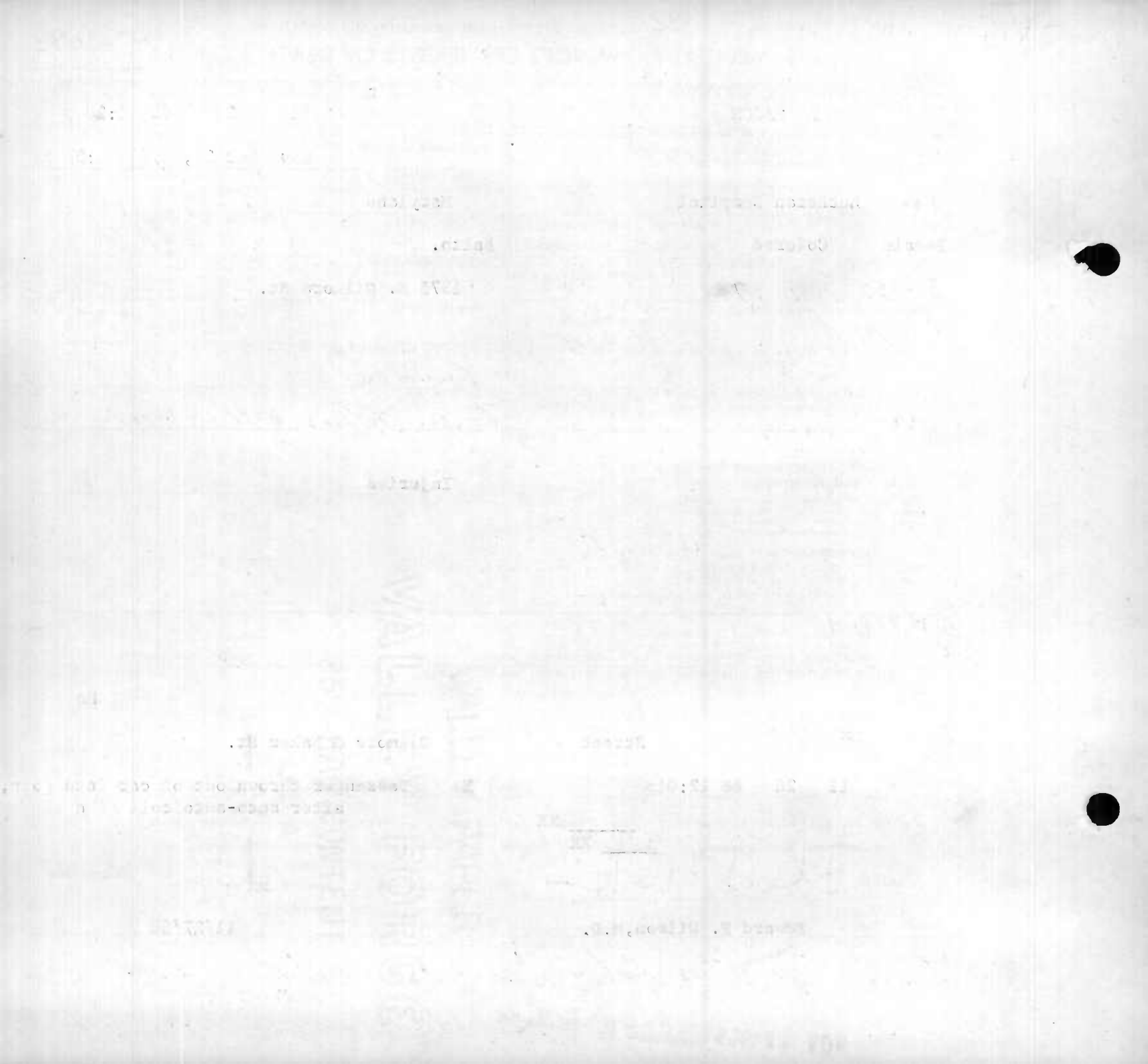
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR ADDRESS

Kelson Funeral Home 1340 N. Calhoun St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11893

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11893

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Maxwell Kyle

2. DATE AND HOUR OF DEATH

November 24, 1968

2 30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

99 Union Memorial Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE
Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

522 Walker Ave

5. SEX

Male

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

Feb. 28, 1903

9. AGE (In years
last birthday)

65

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Photo Engraver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John M Kyle

14. MOTHER'S MAIDEN NAME

Sadie Rhoads

15. Was Deceased Ever in U. S. Armed Forces?

No

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

185-05-8663

17. INFORMANT

Mrs Grace L Kyle

ADDRESS

Same

18.

410.91

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

acute Myocardial Infarction

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

arteriosclerosis Cardiovascular
Disease

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Immediate

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At Work ☒ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1943 to Oct 23 1968,
that (I) (we) last saw the deceased alive on Oct 23 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did not) view the body after death.

23A. SIGNATURE

James E White M.D.

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

Nov. 25/68

23C. PHYSICIAN'S
NAME (Type)

James E White M.D.

DEGREE

5214 Harford Rd Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/27/68

24C. NAME OF CEMETERY or CREMATORY

Hillside

24D. LOCATION

Philadelphia, Penna.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 27 1968

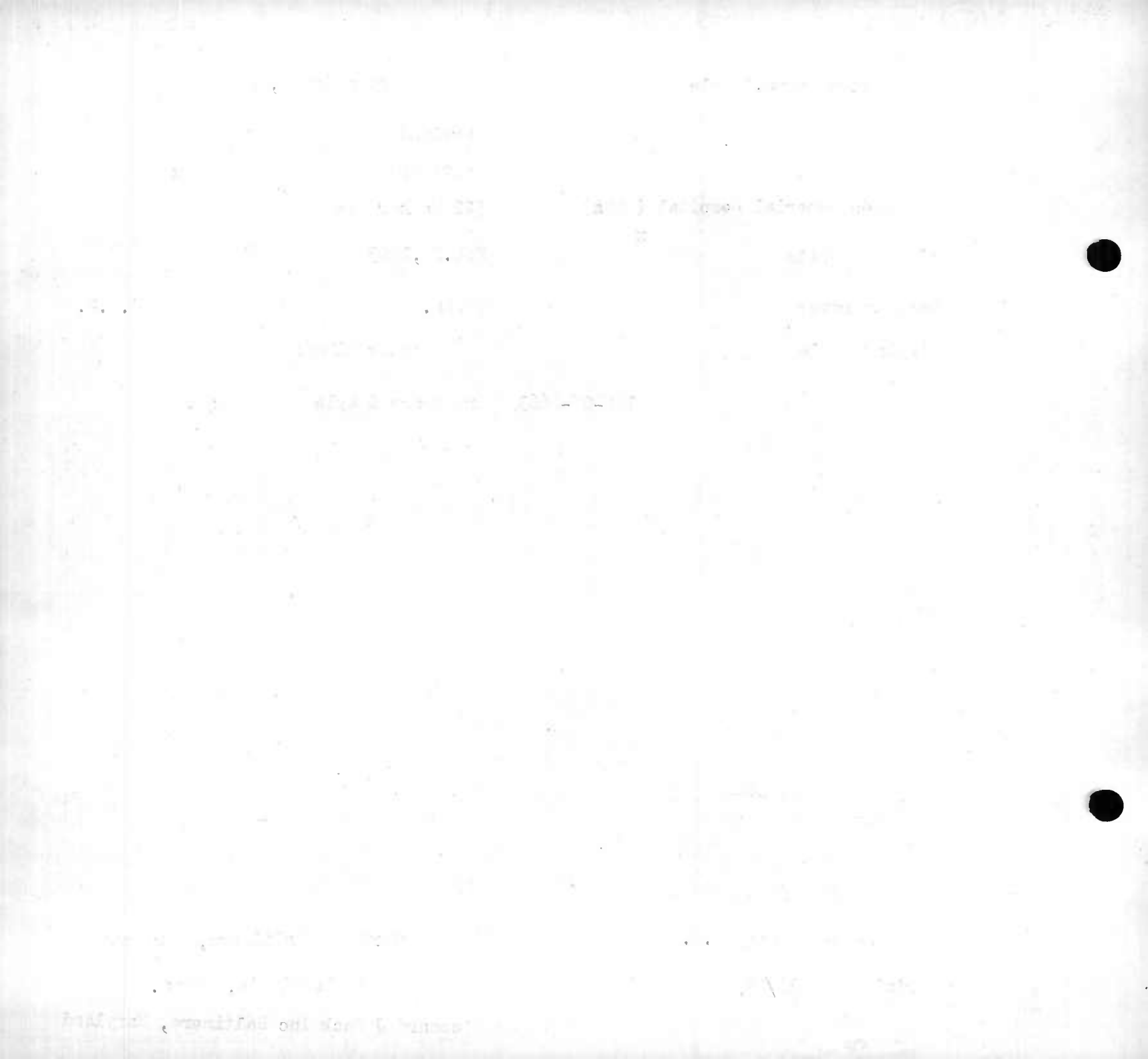
25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Leonard J Ruck Inc Baltimore, Maryland

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11894 CERTIFICATE OF DEATH

REG. NO. 68-11894

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Irene Lucy Sullivan</i>		2. DATE AND HOUR OF DEATH <i>11-25-68</i> <i>3:25</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 House in Pines, Belair Rd.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto.</i> C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2010 East 31st St</i>		
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-5-1892</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Robert Seymour</i>		14. MOTHER'S MAIDEN NAME <i>Annie Seymour</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-14-8552</i>		17. INFORMANT <i>Dorothy Bradfield</i>	
18. <i>437.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral arteriosclerosis</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>5 years</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <i>334 X II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1958</i> to <i>Nov. 25 1968</i> , that (I) was lost saw the deceased alive on <i>Oct. 17 1968</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ronald Jandorf</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>11-25-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>R Donald Jandorf</i>		23D. ADDRESS <i>7403 Hartford Rd</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-29-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Gardens of faith</i>	
24D. LOCATION <i>Balto. Md.</i>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 27 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jandorf</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>	
25D. ADDRESS <i>Balto. MD.</i>					

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11895				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11895 4	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BARNARD, BABY GIRL				11/25/68 11 40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Md.			
42 Sinai Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 6826 Sturbridge Dr.							
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/25/68	
9. AGE (In years lost birthday)		10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME Bruce K. Barnard				14. MOTHER'S MAIDEN NAME JUDITH M. Manning			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT HOSPITAL RECORD		ADDRESS	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anoxic Brain Damage			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Abruptio placentae & Primary apnea DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 761.0 II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/25 1968 to 11/25 1968, that (I) (we) last saw the deceased alive on 11/25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Alan Mitnick, M.D.				23B. DATE SIGNED 11/25/68			
23C. PHYSICIAN'S NAME (Type) ALAN MITNICK M.D.				23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/29/68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Waltham, Mass.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto.		ADDRESS Md.	

FUNERAL DIRECTOR: IMPORTANT

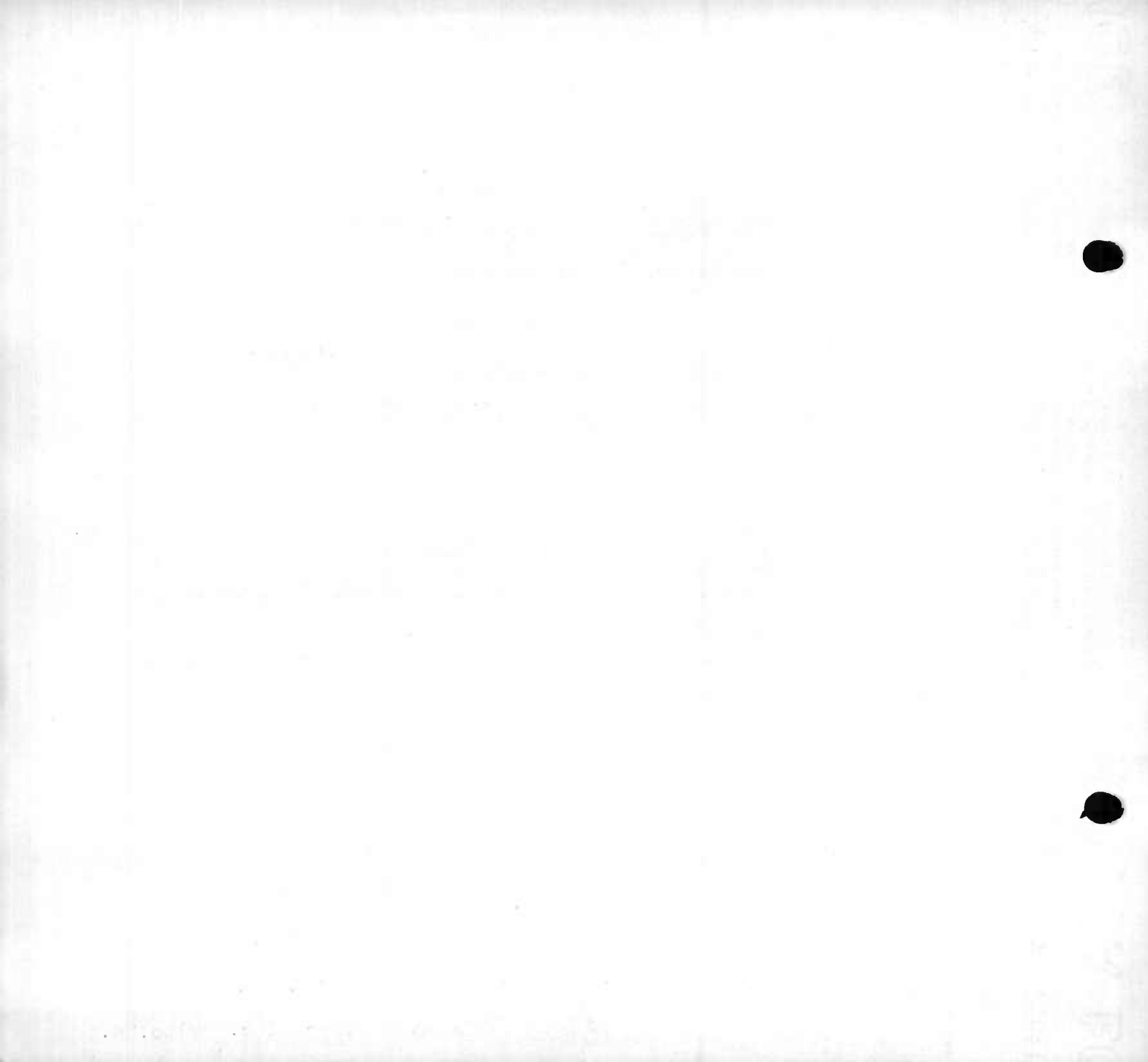
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11896

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

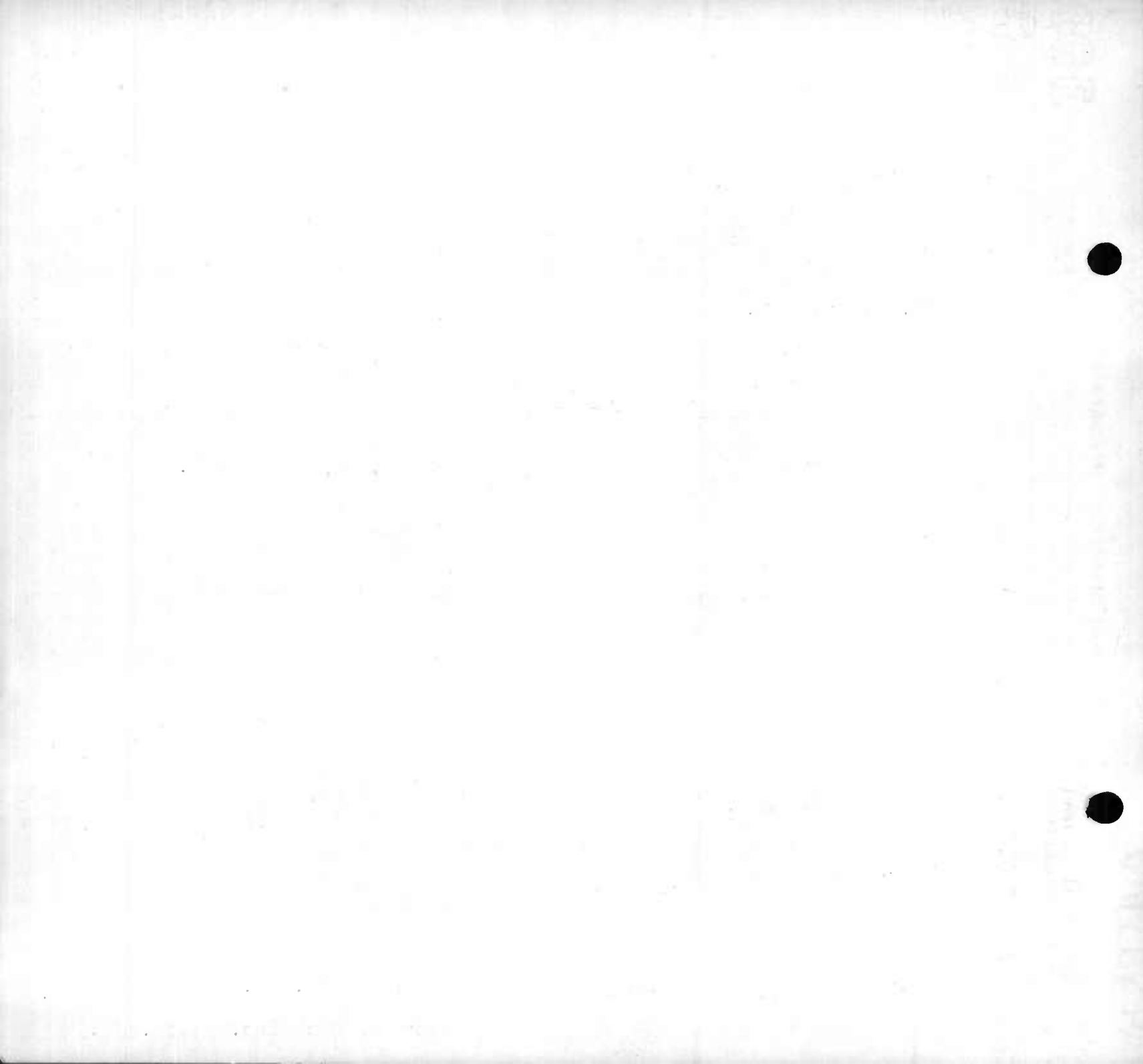
REG. NO. 68-11896

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES B. MODJESKY		2. DATE AND HOUR OF DEATH 11/26/68 1245 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEM. HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 27-05	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3/13/06		9. AGE (In years last birthday) 62		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAXI DRIVER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENN.	
12. CITIZEN OF WHAT COUNTRY? U-S-A		13. FATHER'S NAME Edward MODJESKY		14. MOTHER'S MAIDEN NAME Burkuskia SOPHIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Evelyn Mazzola same	
18. 450X140119 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Carotid Artery DUE TO, OR AS A CONSEQUENCE OF: (B) Pressure Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF: (C) TBC, Emphysema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 5 hrs.		19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 465X II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/22 19 68 to 11/26 19 68 , that (I) (we) last saw the deceased alive on 11/26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALLAN D. JENSEN, M.D.		23B. DATE SIGNED 11/26/68		23C. PHYSICIAN'S NAME (Type) ALLAN D. JENSEN, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/29/68		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR Leonard J. Ruck	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		25D. ADDRESS Balto. Md.		25E. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11897	
68-11897 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Lawrence Frederick Norman		2. DATE AND HOUR OF DEATH 11-26-68 8:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 27-38		
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland Gen. Hospital			C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 5606 Loch Raven Blvd.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 09-12-93	9. AGE (In years lost birthday) 75 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. B. & O. R.R.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Massachusetts	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George A. Norman			14. MOTHER'S MAIDEN NAME Lilly E. Ward		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705-05-3143		17. INFORMANT Wife	
18. 427.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 434.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: UREMIA			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-25 19 68 to 11-26 19 68 , that (I) (we) last saw the deceased alive on 11-26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Delfa C. Young, M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11/29/68		Moreland Memorial Park Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 27 1968		Robert E. Edwards		Leonard J. Ruck Inc. Balto. Md.	



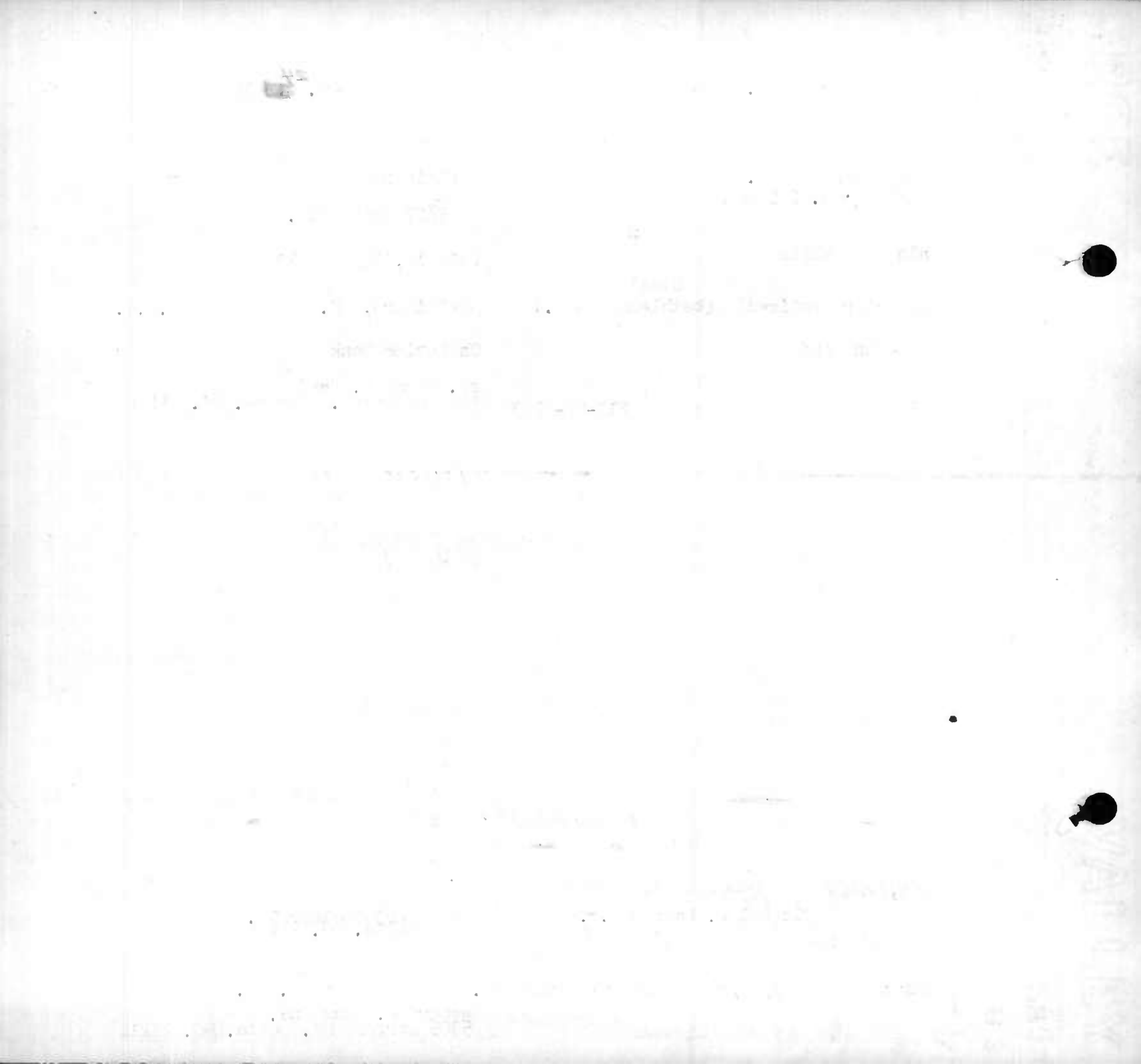
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11898 CERTIFICATE OF DEATH

REG. NO. 68-11898

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Arthur N. Bond		2. DATE AND HOUR OF DEATH Nov. 24 1968 5:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 5627 Knell Ave. Balto. Md. 21206		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5627 Knell Ave.	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1895		9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector (retired)		10B. KIND OF BUSINESS OR INDUSTRY Steel (Bethlehem Corp.)		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME John Bond			14. MOTHER'S MAIDEN NAME Catherine Denk		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-1143		17. INFORMANT Mrs. Sarah G. Bond 5627 Knell Ave. Balto. Md. 21206	
18. 153.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 153.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Toxic Absorption (B) Carcinoma of Sigmoid (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 19 66 to November 24 19 68 , that (I) (we) lost saw the deceased alive on November 23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael J. Dausch, M.D.				23B. DATE SIGNED 11/25/68	
23C. PHYSICIAN'S NAME (Type) Michael J. Dausch, M.D.				23D. ADDRESS 4636 Belair Rd. Balto. Md. 21206	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/27/68		New Cathedral Cem. Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 27 1968		Robert E. Taylor		Leonard J. Ruck Inc. 5305 Harford Rd. Balto. Md. 21214	



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S-363

68-11899 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11899

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH E. STEWART		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 25, 1968 9:20 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 25, 1968 9:20 P.M.	
6. SEX male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
7. RACE negro		C. CITY OR TOWN Baltimore	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH APR. 15, 1905		E. STREET AND NUMBER 734 S. Hanover St.	
10. AGE (In years lost birthday) 63		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME WILLIAM W. STEWART	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME GEORGIANNA YOUNG	
14B. KIND OF BUSINESS OR INDUSTRY		16. INFORMANT LENORA POWELL	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. ADDRESS 807 S. HANOVER ST		19. CAUSE OF DEATH Pulmonary Hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) No	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/26/68			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-29-68	
24C. NAME OF CEMETERY or CREMATORY MOUNT CALVARY		24D. LOCATION (City, town, or county) (State) ARUNDEL Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968		25B. NAME OF REGISTRAR Robert E. Fairbank	
25C. FUNERAL DIRECTOR J. L. BROWN & SON		25D. ADDRESS 123 W. MONTGOMERY ST.	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-28-02 BY SP-6 JAM/STW

WILLIAM H. STEWART

ASSISTANT ATTORNEY GENERAL

RECEIVED FOR DIRECTOR

WILLIAM H. STEWART

ASSISTANT ATTORNEY GENERAL

BURIAL 11-28-02 Mount Carmel Burial Co. Inc.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

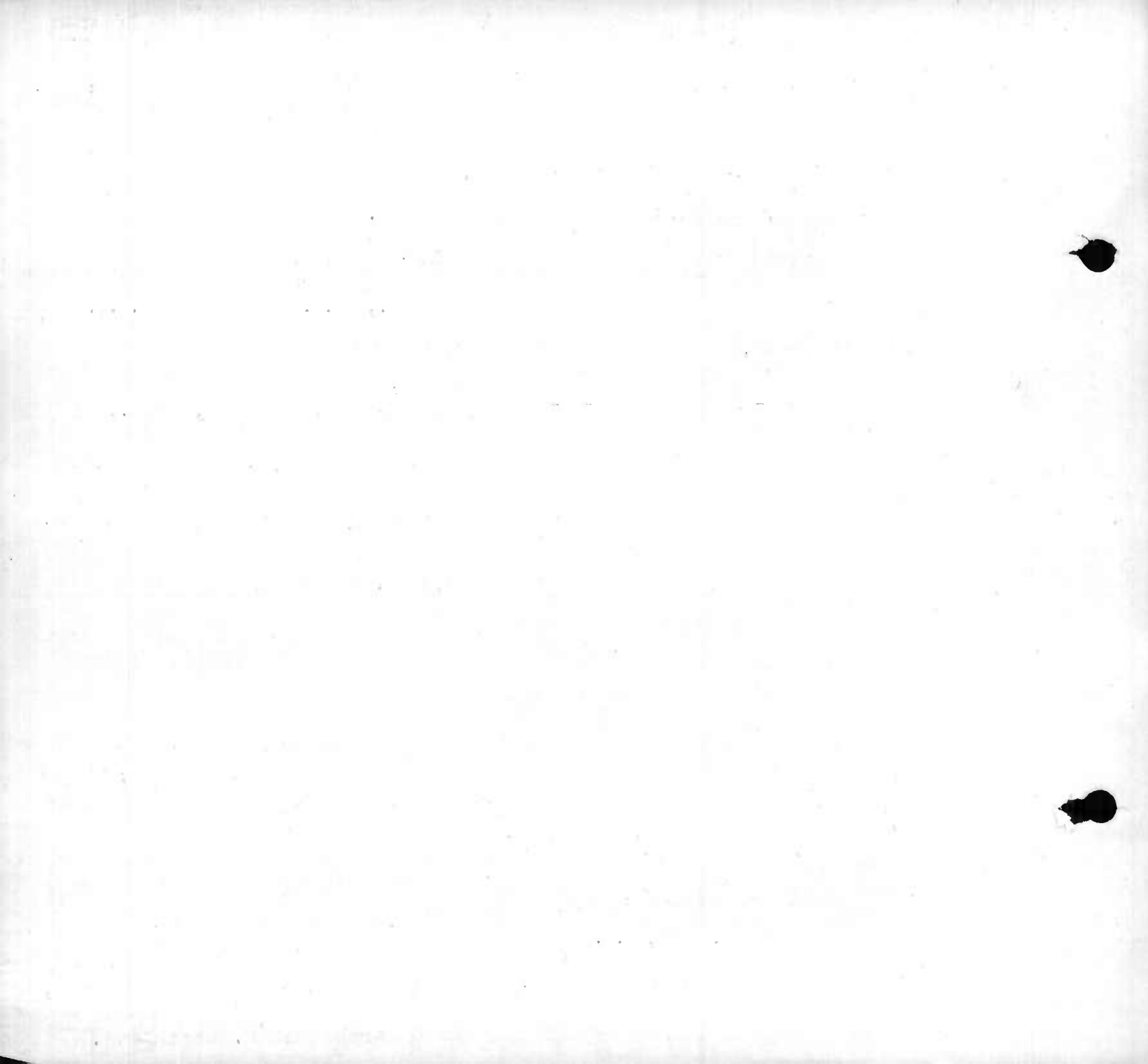
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11900 CERTIFICATE OF DEATH

REG. NO. 68-11900

BIRTH NO.		1. NAME OF DECEASED (Type or Print) RICHARDSON, William Thomas		2. DATE AND HOUR OF DEATH 11/26/68 5:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 8-04		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2311 E. Preston Street	
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/14	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Anson Co., N.C.	
13. FATHER'S NAME Lonnie Richardson		14. MOTHER'S MAIDEN NAME Minnie Marshall		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/9/42 - 10/8/45		16. SOCIAL SECURITY NO. 239-14-6209		17. INFORMANT VA Hospital Records 3900 Loch Raven Boulevard, Balto., Md 21218	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic heart disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2 years (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 hours	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 13th 1968 to November 26th 1968 , that (I) (we) last saw the deceased alive on November 26th 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  DEGREE				23B. DATE SIGNED 11/26/68	
23C. PHYSICIAN'S NAME (Type) YOUNG E. CHUN, M.D. DEGREE		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/29/68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION 5501 Frederick		24E. LOCATION (City, town, or county) Baltimore, Md			
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Wm G. March	
				ADDRESS 928 E. North Ave.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11901

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

ROOSEVELT BELL

2. DATE
OF DEATHKnown ☐ Estimated ☐

Month Day Year

Hour

11 23 68

11:45

a

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital D.O.A.

3. DATE
PRONOUNCED DEAD

Month Day Year

Hour

November 23, 1968

11:45

a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland.

15-12

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Feb. 28, 1946

10. AGE (In years
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3813 Park Hgts. Ave.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Herbert Bennett

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Fearnuone Bell Nelson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

239-66-3247

18. INFORMANT

ADDRESS

Mrs. F. Nelson 681 E. 139th St NYC

19. E812,10

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Injuries
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

St.

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

McCulloh St. 80ft. N. of Liberty Hgts

22D. TIME
OF INJURY
(APPROX.)

11 23 68 11:30

22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject driver in auto-auto coll.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 24, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/30/68

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Ahoskie, N.C.

25A. DATE RECEIVED BY HEALTH DEPT

NOV 27 1968

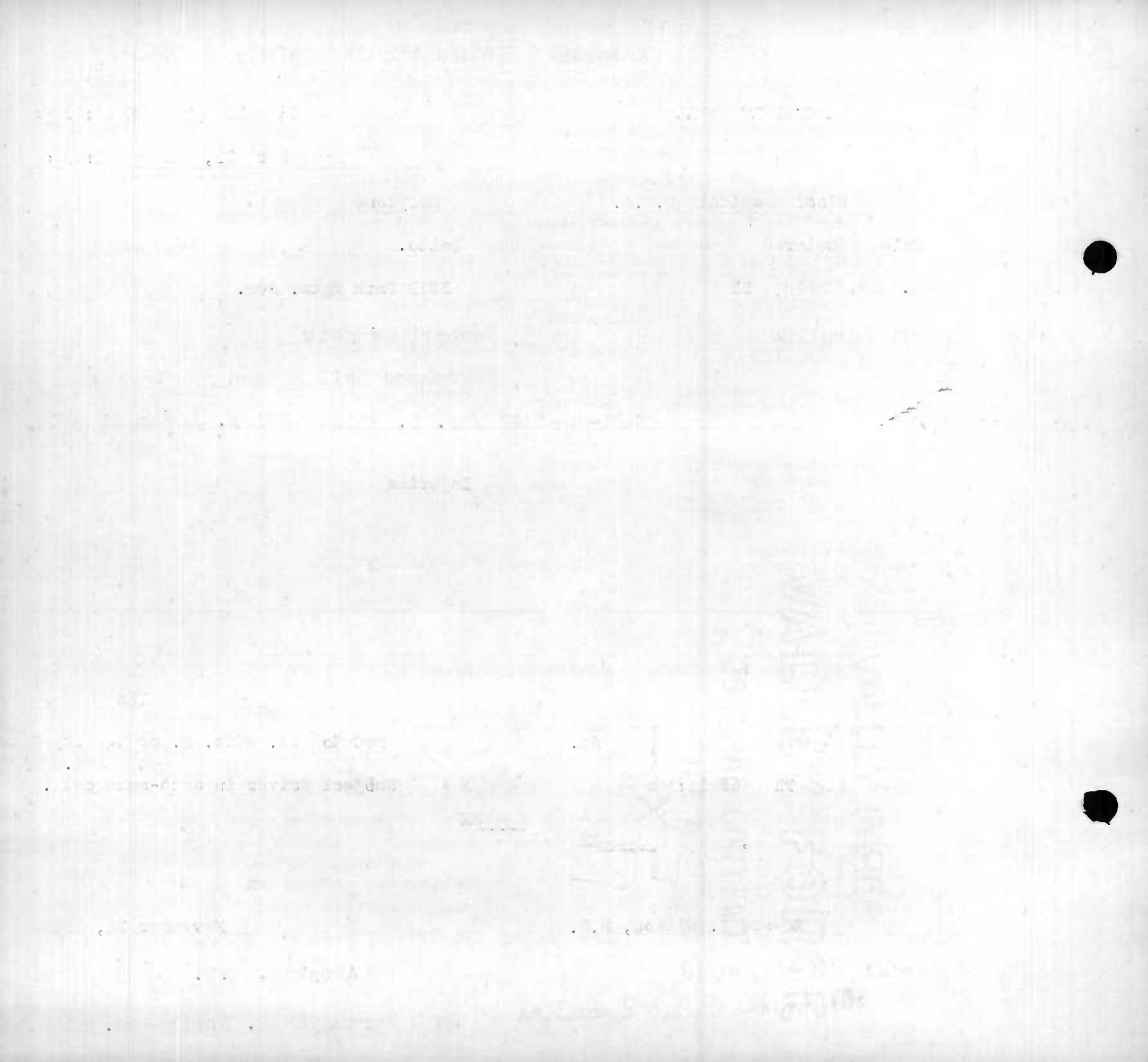
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

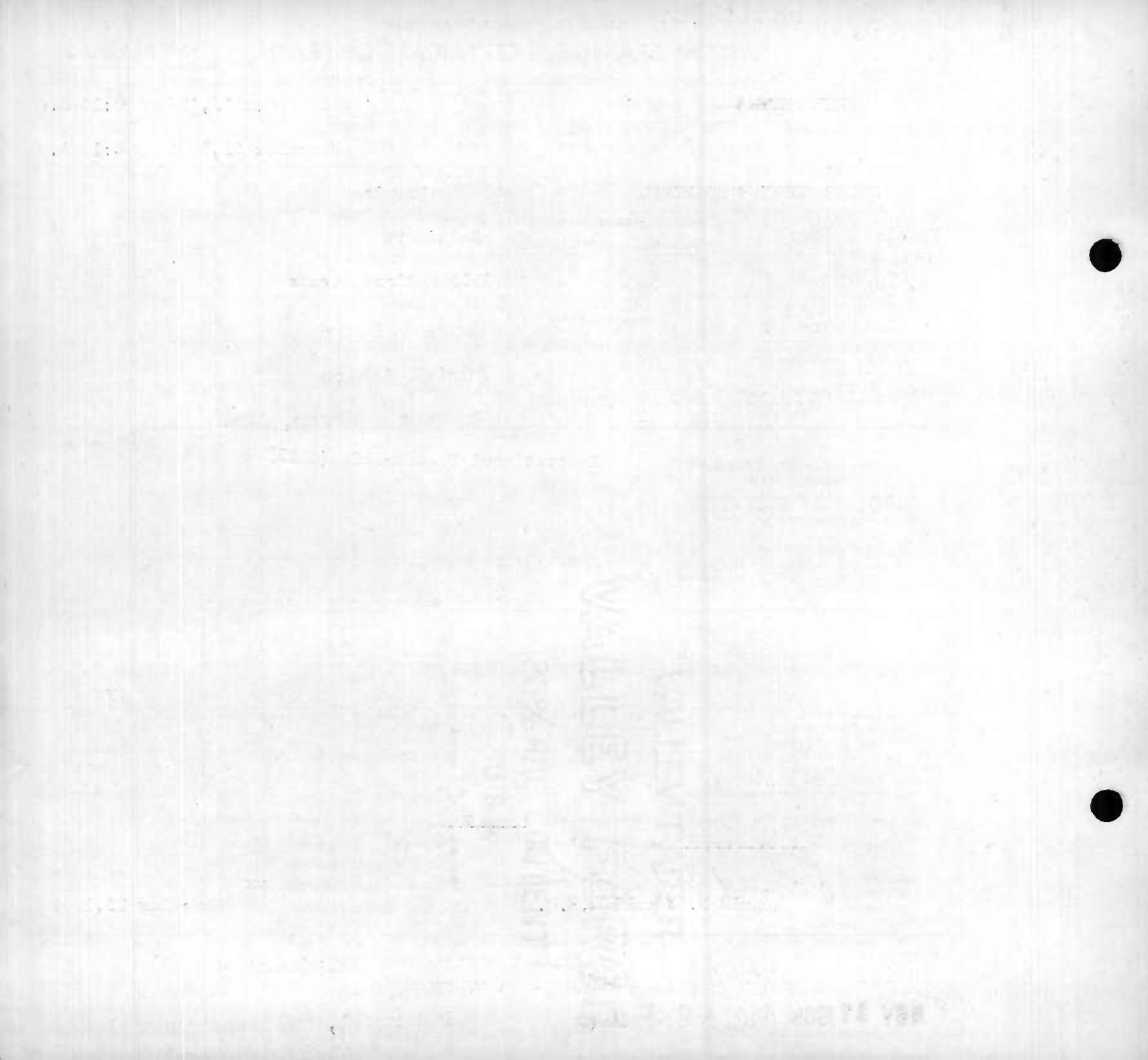
25C. FUNERAL DIRECTOR

ADDRESS

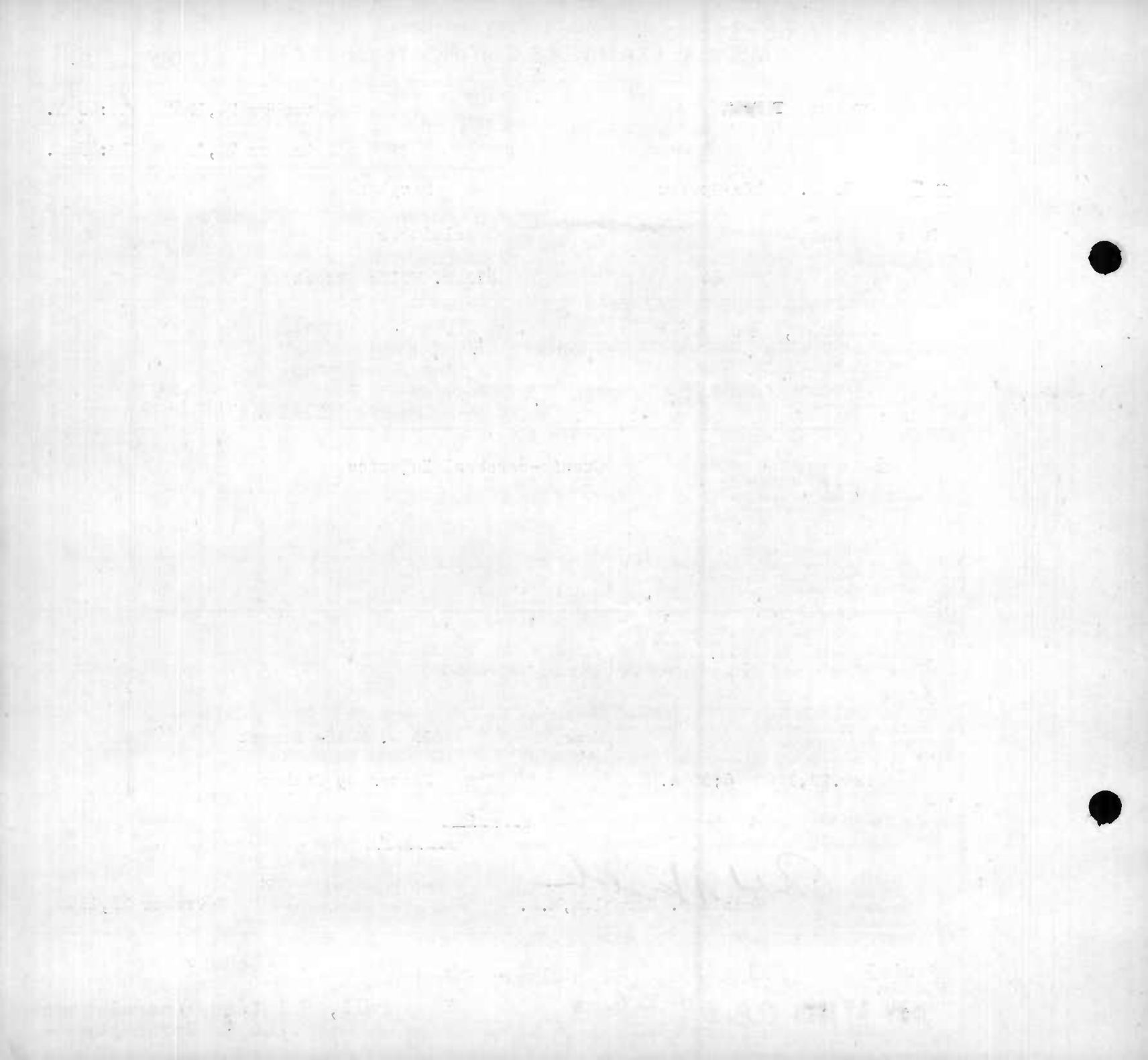
Wm C March, 928 E. North Ave. Balto. Md



BIRTH NO. 68-15536		68-11902		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		68-11902		REG. NO.	
1. NAME OF DECEASED (Type or Print) BERNADETTE				HEARD				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 25, 1968		Hour 8:10 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year November 25, 1968				Hour 8:10 A. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7-04	
9. DATE OF BIRTH 8/14/68		10. AGE (In years lost birthday) 3		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1035 Rutland Avenue					
11. BIRTHPLACE (State or foreign country) Baltimore Md				12. CITIZEN OF U S A		13. FATHER'S NAME Wayne M Heard					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Muriel Alston					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT Mr Wayne M Headr, Same		ADDRESS			
19. 486X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH Interstitial Pneumonitis (SDII) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
525X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED November 25, 1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/29/68		24C. NAME OF CEMETERY or CREMATORY National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md					
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968				25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR I Carroll, Halstead Funeral Home		ADDRESS 1206 W North Ave			



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 68-11903	
1. NAME OF DECEASED (Type or Print) GEORGE PERNELL				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 24, 1968		Hour 10:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 815 N. Wolfe Street				3. DATE PRONOUNCED DEAD Month Day Year November 24, 1968		Hour 10:45 A.M.	
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 2/4/24				10. AGE (In years last birthday) 44 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 815 N. Wolfe Street	
11. BIRTHPLACE (State or foreign country) Baltimore, Md				12. CITIZEN OF U S A		13. FATHER'S NAME Albert Purnell	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Edna Mae Evans	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO.		18. INFORMANT Mrs Maggie Williams 4814 Lanier St	
19. E 968 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH Cranio-cerebral Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 815 N. Wolfe Street 7-05				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Nov. 22, 1968 4:30 A.M.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Beaten by father			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED November 25, 1968							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/28/68		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR I Carroll, Halstead Funeral Home		ADDRESS 1206 W North Ave	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11904

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRY C. TATE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 25, 1968		Hour 11:30 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year November 25, 1968		Hour 11:30 A.M.
6. SEX Male		7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3/15/17		10. AGE (In years lost birthday) 50?	11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME James A Murray		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
15. MOTHER'S MAIDEN NAME Florence Tates		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 218-01-4366
18. INFORMANT Mrs Florence Gibbs		19. ADDRESS 2331 Reistertown Rd		20. CAUSE OF DEATH Craniocerebral Injuries
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E988X		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E902.7		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fatty Metamorphosis of Liver
24A. DATE OF OPERATION 2		24B. CONDITION FOR WHICH OPERATION WAS PERFORMED		24C. AUTOPSY? (Yes or No) yes
25A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Police station		25C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Western police district
26A. TIME (Month) (Day) (Year) (Hour) Nov. ?? 68 UNK.		26B. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		26C. HOW DID INJURY OCCUR? Fell from bench while in cell and struck head
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>				
28. ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		30. DATE SIGNED November 25, 1968
31. EXAMINER'S NAME (Type)		32. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		33. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
34A. BURIAL CREMATION, REMOVAL (Specify) Burial		34B. DATE 11/30/68	34C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	34D. LOCATION (City, town, or county) (State) Baltimore Md
35A. DATE REC'D BY HEALTH DEPT. NOV 27 1968		35B. NAME OF REGISTRAR Robert E. Tidy		35C. FUNERAL DIRECTOR I Carroll
36A. ADDRESS Halstead Funeral Home		36B. ADDRESS 1206 W North Ave		

Paul M. Kunkle

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11905 CERTIFICATE OF DEATH

REG. NO. 68-11905

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Josef Shema		2. DATE AND HOUR OF DEATH 11-26-1968 5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Retired		10B. KIND OF BUSINESS OR INDUSTRY Shema Furniture Co. Baltimore, Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Rudolph Shema				14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 210-14-1529A		17. INFORMANT Mrs. Emily Shema	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anteriosclerotic heart disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anteriosclerotic heart disease		(B) DUE TO, OR AS A CONSEQUENCE OF: Anteriosclerotic 10 yr.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.0 II		(C) Urinary tract infection		2 mo	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 13 19 68 to Nov 26 19 68 , that (I) (we) last saw the deceased alive on 11/18 19 68 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Norman R Freeman				23B. DATE SIGNED 11/27/68	
23C. PHYSICIAN'S NAME (Type) Dr. Norman Freeman				23D. ADDRESS 11 W. 29th Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-30-68		24C. NAME OF CEMETERY or CREMATORY Memorial Park Cemetery Alleghany Co.	
24D. LOCATION (City, town, or county) (State) Pittsburg, Pa.		25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co			
ADDRESS 4905 York Road Balto., Md. 21212					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11906

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)KATHERINE / E. MIDDLEKAMP
~~MIDDLEKAMP~~2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

11

26

68

5:55 p

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CERTIFICATE AMENDED

St. Agnes Hospital D.O.A 12-2-68

3. DATE
PRONOUNCED DEAD

November 26, 1968

5:55 p

M.

5. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

Pa.

RD #3

V-35

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Female

White

Kennett

Kenneth Square

YES ☐NO ☒

9. DATE OF BIRTH

10. AGE (In years
lost birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

2-29-1892

76

E. STREET AND NUMBER

RD #3

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Maryland

USA

John H. Elder

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Housewife

Own Home

Katie Schubard

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

No

171-26-5000

Worall & Kuzl

Kenneth Square Pa.

19. 412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/27/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

11-30-68

St. Patricks

Kennett

Kenneth Square

Pa.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 27 1968

Robert E. Jenkins

H.W. Jenkins & Sons Co. 4905 York Rd.

Balto., Md.

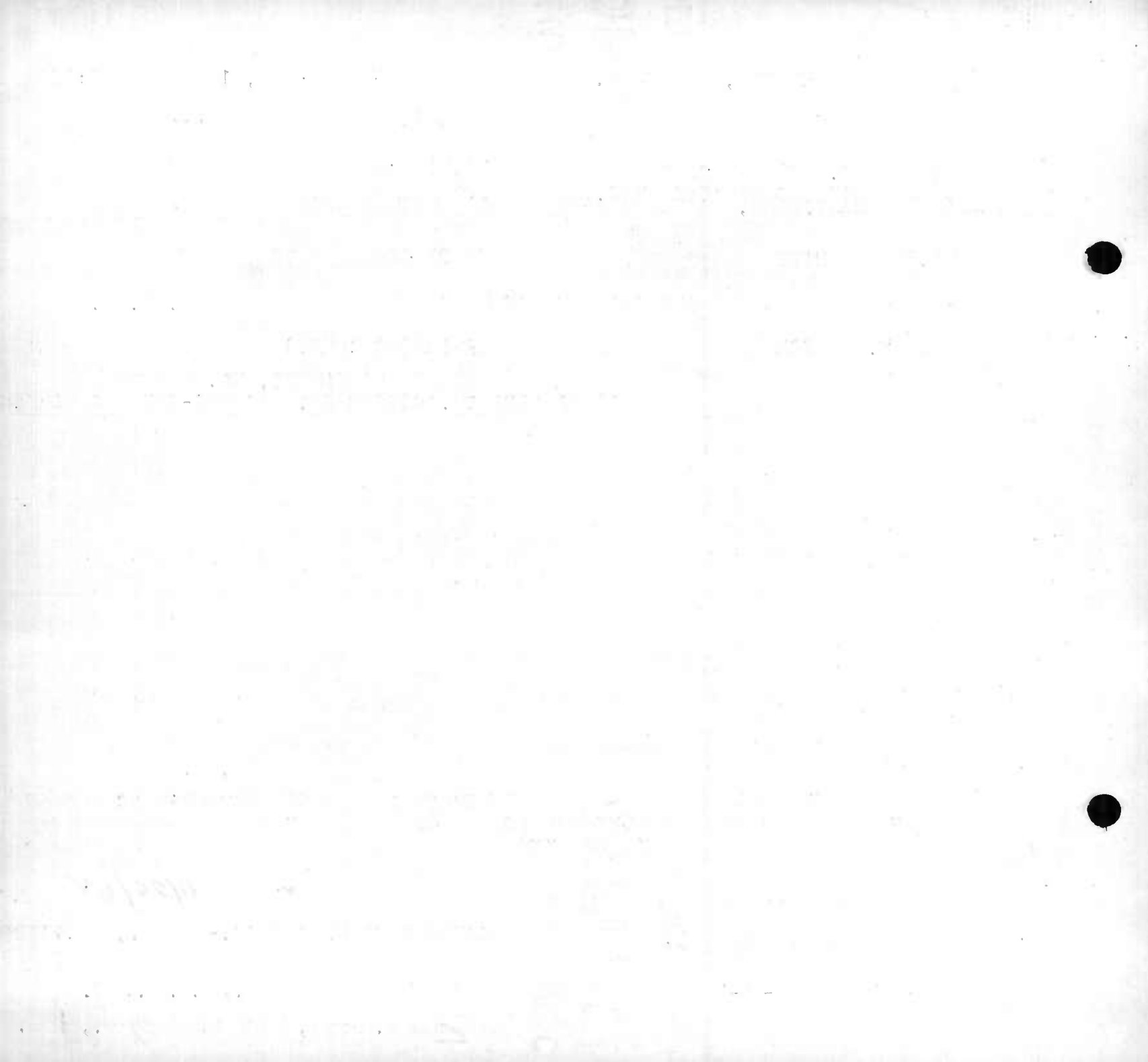
W.F. 1007B

68-11907 CERTIFICATE OF DEATH

FUNERAL DIRECTOR: IMPORTANT

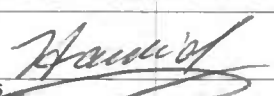
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

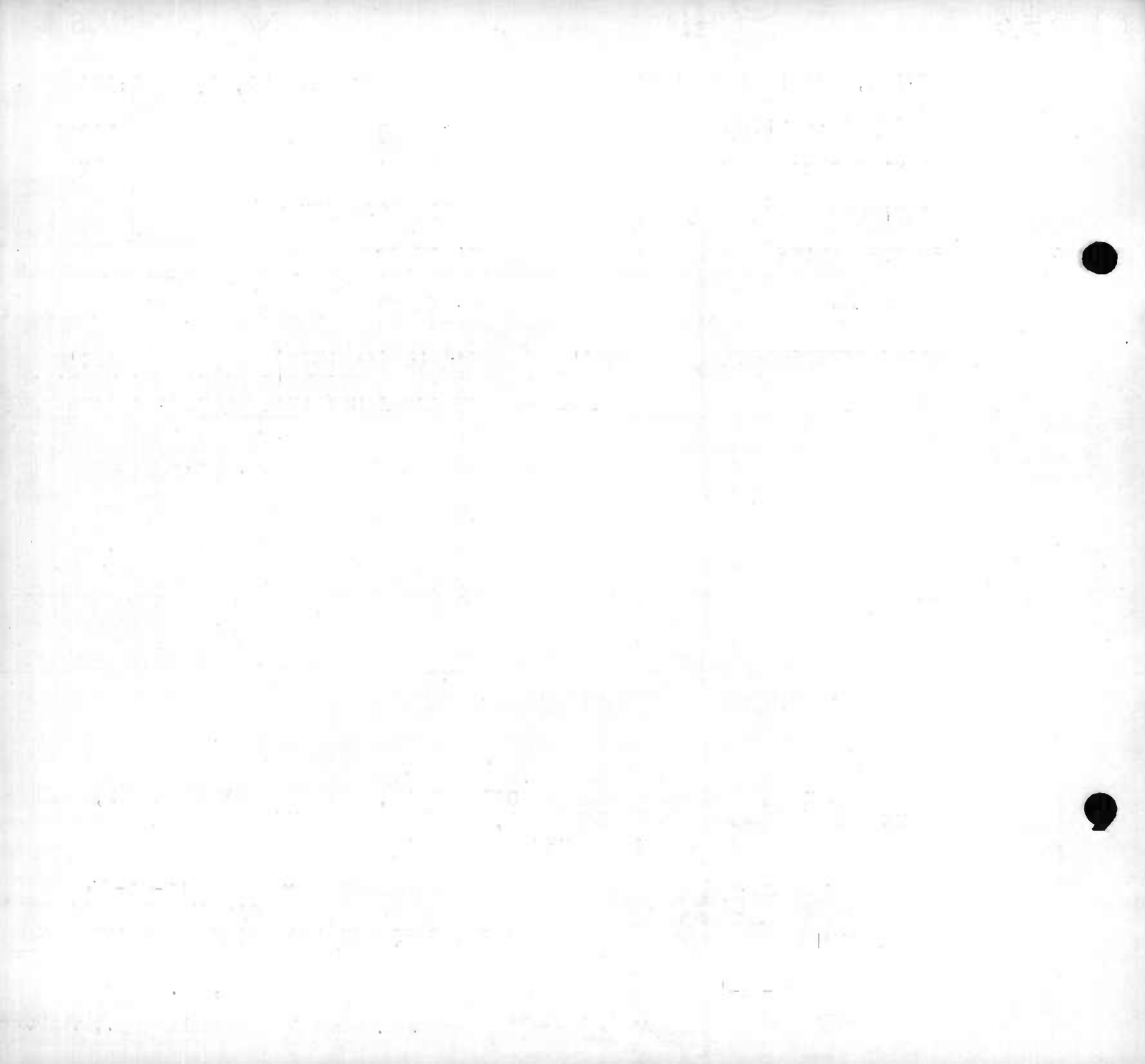
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		KURSCH, GEORGE H.		NOVEMBER 20, 1968 5:15A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVES BALTIMORE, MARYLAND 21229				A. STATE MARYLAND B. COUNTY 9.9.C. 21225 52.00 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 248 MEADOW ROAD	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08 07 90	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER		10B. KIND OF BUSINESS OR INDUSTRY MARYLAND DRYDOCK		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOHN H. KURSCH			
14. MOTHER'S MAIDEN NAME LEVINA (MC CLUEY)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 214 03 2103		17. INFORMANT ADDRESS BALTIMORE, MD. 21229 ST. AGNES HOSP. RECORDS-CATON & WILKENS			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute pulmonary edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Congestive heart failure (C) Diabetes 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 1 19 68 to NOVEMBER 20 19 68, that (X) (we) last saw the deceased alive on NOVEMBER 20 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Padron				23B. DATE SIGNED 11/20/68	
23C. PHYSICIAN'S NAME (Type) Isidoro Padron				23D. ADDRESS CATON & WILKENS AVES.-BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-23-'68		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION Ritchie Hwy., A.A.Co., Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR George J. Goyce, 4001 Ritchie Hwy., Balto.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11908
68-11908				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MCGINN, (FRIEDA) ANNA FREDRICKA		2. DATE AND HOUR OF DEATH NOVEMBER 21, 1968 2:30A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION WILKENS & CATON AVENUES BALTIMORE MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND G.A. Co 52-00 21122 B. COUNTY C. CITY OR TOWN PASADENA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER PEKIN ROAD BOX 299		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04 18 08	9. AGE (In years lost birthday) 60 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME FRANK RITERSHOFFER		
14. MOTHER'S MAIDEN NAME CARRIE (ALBIKER)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 211-11-8040		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		
18. 211.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Alumina & Liver Cirrhosis DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 211 X II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from OCTOBER 17, 1968 to NOVEMBER 21, 1968 , that (X) (we) lost saw the deceased alive on NOVEMBER 21, 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED 11-21-68		23C. PHYSICIAN'S NAME (Type) DR. HAMID
23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 11-22-'68		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11909

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REC. NO. 68-11909

BIRTH NO.		1. NAME OF DECEASED (Type or Print) THOMAS L. CLARK, Sr.		2. DATE AND HOUR OF DEATH NOVEMBER 21, 1968 2 45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY A. A. C.		C. CITY OR TOWN Deale D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		E. STREET AND NUMBER 2200 N. W. 100			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-20-1902	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Building - Const.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DANIEL CLARK		14. MOTHER'S MAIDEN NAME MARGARET HARDESTY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-5704		17. INFORMANT Mrs. Virginia Clark	
18. 571.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE ACUTE TUBULAR NECROSIS DUE TO, OR AS A CONSEQUENCE OF: LAENNEC'S CIRRHOSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 581.1 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 11 19 68 to Nov. 21 19 68 , that (I) (we) last saw the deceased alive on Nov. 21 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael D. Lutz, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11-22-68	
23C. PHYSICIAN'S NAME (Type) MICHAEL D. LUTZ, M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-25-1968	24C. NAME OF CEMETERY or CREMATORY Parklawn Cemetery		24D. LOCATION (City, town, or county) (State) Rockville, Montgomery, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Georgia Ave.	

ROUTE TUBALIN RECORD

LABORERS' CIRCLES

MICHAEL D. LITZ, M.D.
MICHAEL D. LITZ, M.D.

5-460

68-11910

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11910

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FLOYD S. SILER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 24, 1968 11:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 25, 1968 5:53 P.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH APRIL 13 1918		10. AGE (In years last birthday) 50	
11. BIRTHPLACE (State or foreign country) SILER CITY N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT SILER		14. MOTHER'S MAIDEN NAME SALLIE MOORE	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		16. KIND OF BUSINESS OR INDUSTRY CONTRACTOR	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		18. SOCIAL SECURITY NO. 220-07-9961	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Lobar Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 481X ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 490X OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fatty Alteration of The Liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 11/26/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 11/30/68	
24C. NAME OF CEMETERY or CREMATORY MT + AUBURN		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 29 1968		25B. NAME OF REGISTRAR Robert E. Fabela	
25C. FUNERAL DIRECTOR James G. Hager		ADDRESS 638 N GILMAN ST	

WALLACE BROWN

NOV 20 1902
Lester M. Brown
Lester M. Brown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-632		68-11911		BALTIMORE CITY HEALTH DEPT-SAB		REG. NO.		68-11911	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mary Murdock</i>				2. DATE AND HOUR OF DEATH <i>27 Nov 68</i> <i>3</i> <i>A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>16-05</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>31</i> <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>						C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER <i>2544 Arunah Avenue</i>		<i>21216</i>	
5. SEX <i>Female</i>		6. RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-9-1893</i>		9. AGE (In years last birthday) <i>75</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Put Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Hewe Ford</i>						14. MOTHER'S MAIDEN NAME <i>Annie Brown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Records: BCH-4940 Eastern Avenue 21224</i>			
18. <i>163.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i> (B) <i>Carcinoma of lung brain</i> (C) <i>Carcinoma of lung</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 da</i> <i>1 mo</i> <i>1 mo</i>	
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>11/11/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca of brain</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>-</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <i>Nov 1</i> 19 <i>68</i> to <i>Nov 27</i> 19 <i>68</i> , that (1) (we) last saw the deceased alive on <i>Nov 26</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>David J. Riley MD</i>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>27 Nov 68</i>	
23C. PHYSICIAN'S NAME (Type) <i>David J. Riley</i>						23D. ADDRESS <i>4940 Eastern Avenue, Baltimore City</i> <i>Baltimore, Maryland 21224 Hospitals</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>11/30/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 29 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Tubbs</i>		25C. FUNERAL DIRECTOR <i>Maryland P/Hugo 6387 Jil more</i>		ADDRESS			

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68-11912 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11912

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GILBERT (PATERSON) PATTERSON

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

November 24, 1968

6:51 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

PROVIDENT HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 24, 1968

6:51 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX
Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS

YES ☒NO ☐

9. DATE OF BIRTH

10-21-1915

10. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2553 Flora Avenue

11. BIRTHPLACE (State or foreign country)

Stareshville N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Oliver H. Patterson

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Lacemaker

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lillian

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

17. SOCIAL
SECURITY NO.

246-01-4606

18. INFORMANT

TERETHA PATTERSON 2316 GANETT RD

ADDRESS

19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

5-71.81

CAUSE OF DEATH

Bronchopneumonia

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Fatty Metamorphosis of Liver

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

581.0

II

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Niles for R.N.K.

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 26, 1968

24. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/24/68

24C. NAME of CEMETERY or CREMATORY

Bacon National

24D. LOCATION

(City, town or county)

(State)

Baltimore

25A. DATE REC'D BY HEALTH DEPT.

NOV 29 1968

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

Margaret K. Hays 638 2911 10th St

ADDRESS

WALTER B. GING

68-11913

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

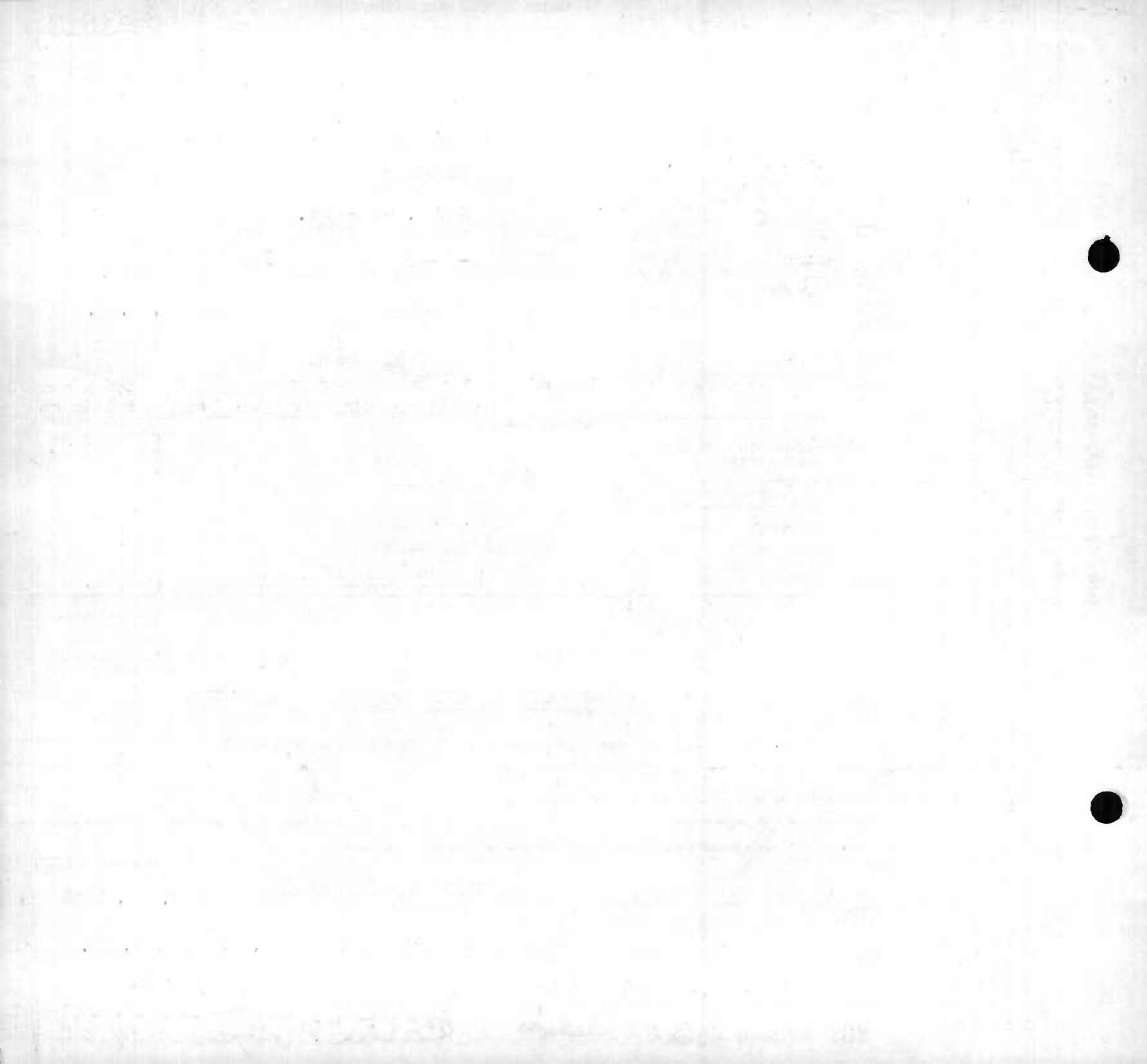
REG. NO.

68-11913

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SARAH JOHNSON		2. DATE AND HOUR OF DEATH November 15, 1968 12⁰⁵ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4940 Eastern Ave. Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 427 N. Carey St. 18-02		
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-05	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Edward Thomas		
14. MOTHER'S MAIDEN NAME Sally Jones			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Baltimore City Hospital Records Baltimore ADDRESS 4940 Eastern		
18. 183.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE CYSTADENOCARCINOMA of Ovary DUE TO, OR AS A CONSEQUENCE OF: CA "in situ" of COLON (B) DUE TO, OR AS A CONSEQUENCE OF: URINARY TRACT INFECTION. (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?			19. 175.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 2/16 19 68 to 11/15 19 68 , that (I) (we) last saw the deceased alive on November 15 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose Torres			23B. DATE SIGNED Nov. 15, 1968		
23C. PHYSICIAN'S NAME (Type) JOSE TORRES M.D.			23D. ADDRESS BCH 4940 Eastern Ave. Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) B		24B. DATE 11/23/68		24C. NAME OF CEMETERY or CREMATORY not known	
24D. LOCATION (City, town, or county) (State) md		25A. DATE REC'D BY HEALTH DEPT. NOV 29 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Joseph G. Run 222 E. North		25D. ADDRESS Calvin E. Cooper 2224 Carroll			



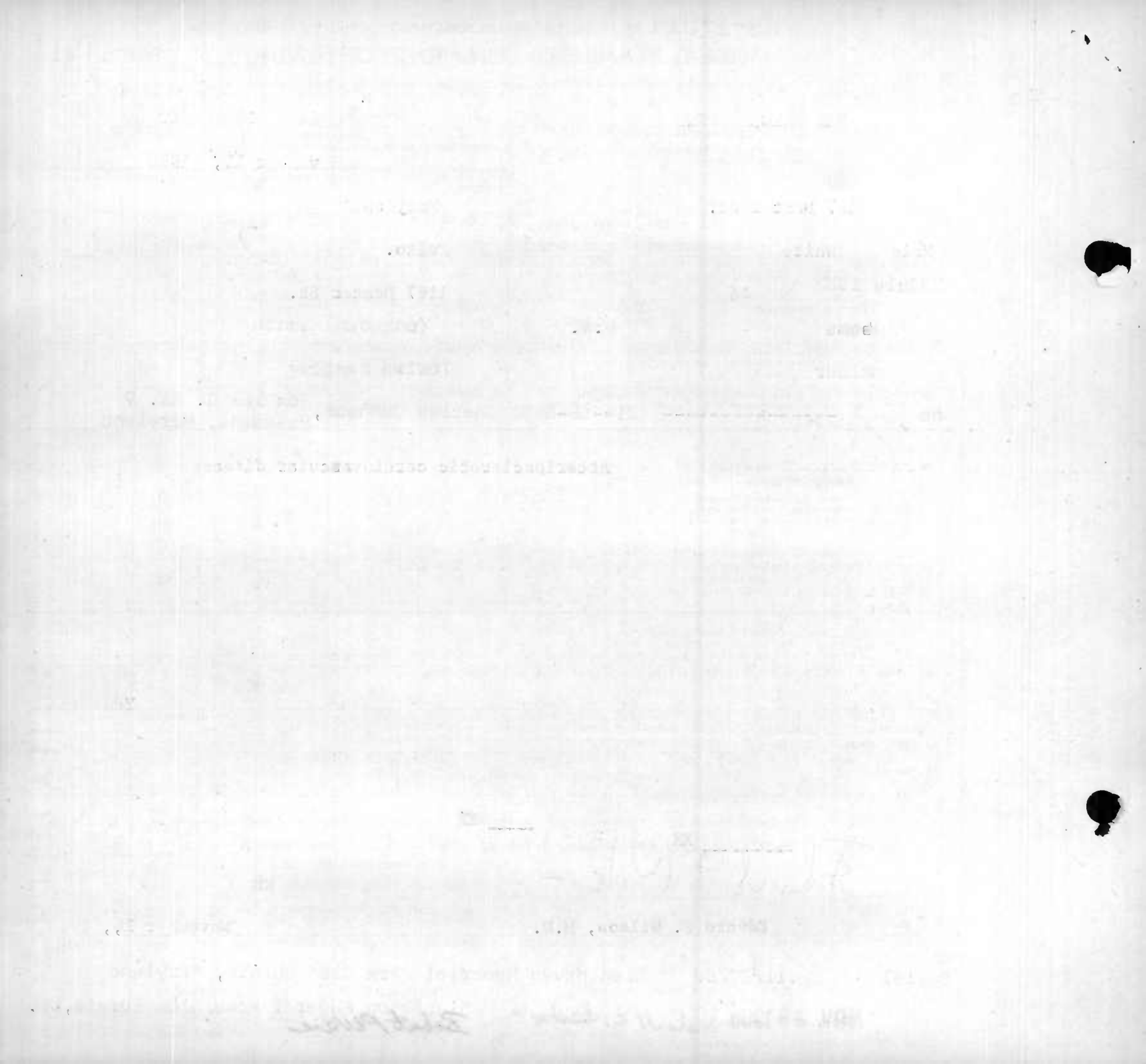
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11914

BIRTH NO.

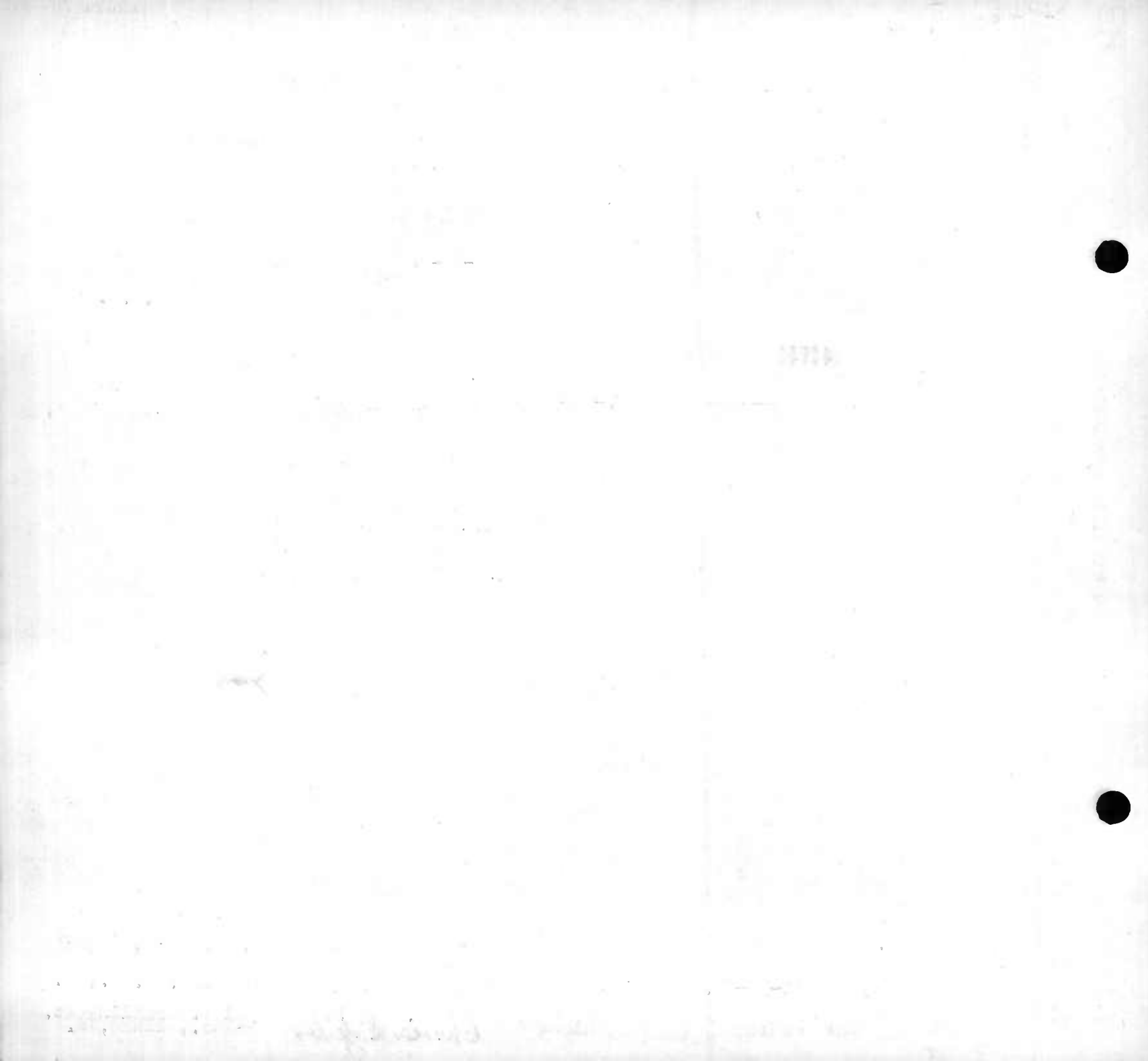
1. NAME OF DECEASED (Type or Print) FREDERICK WENTH		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 11 23 68 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1167 Dexter St.		3. DATE PRONOUNCED DEAD Month Day Year Hour November 23, 1968 M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 23 July 1922		10. AGE (In years lost birthday) 46	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Thelma Bentley		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 214-68-6878		18. INFORMANT Charles Johnson, Box 169 C. Rt. 7 Pasadena, Maryland	
19. CAUSE OF DEATH 41241 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 24, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/68	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 29 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Singleton Funeral Home		ADDRESS Glen Burnie, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B P-652				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11915	
1. NAME OF DECEASED (Type or Print) Alexander J. Prince				2. DATE AND HOUR OF DEATH 11/27/68 12:05 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND		B. COUNTY 26-09	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3501 FOSTER AVENUE #21224							
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-16-91	9. AGE (In years last birthday) 77	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY SEAMAN		11. BIRTHPLACE (State or foreign country) LATVIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUST PRINCE				14. MOTHER'S MAIDEN NAME JULIA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 087-12-9645		17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD			
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia, Uremia, CHF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial infarct				(B) DUE TO, OR AS A CONSEQUENCE OF: 3 wks		(C) 3 wks	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II							
19A. DATE OF OPERATION 3 11/4/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PACEMAKER		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/31 1968 to 11/27 1968 , that (I) (we) last saw the deceased alive on 11/27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert Rosenbaum, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/27/68	
23C. PHYSICIAN'S NAME (Type) DR. ROBERT ROSENBAUM				23D. ADDRESS BCH-4940 EASTERN AVENUE, BALTIMORE, MD 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-30-68.	24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd. Ba. Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 29 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Charles J. Giller		ADDRESS 901 S. Conkling St. Balto., 21224, Md.	



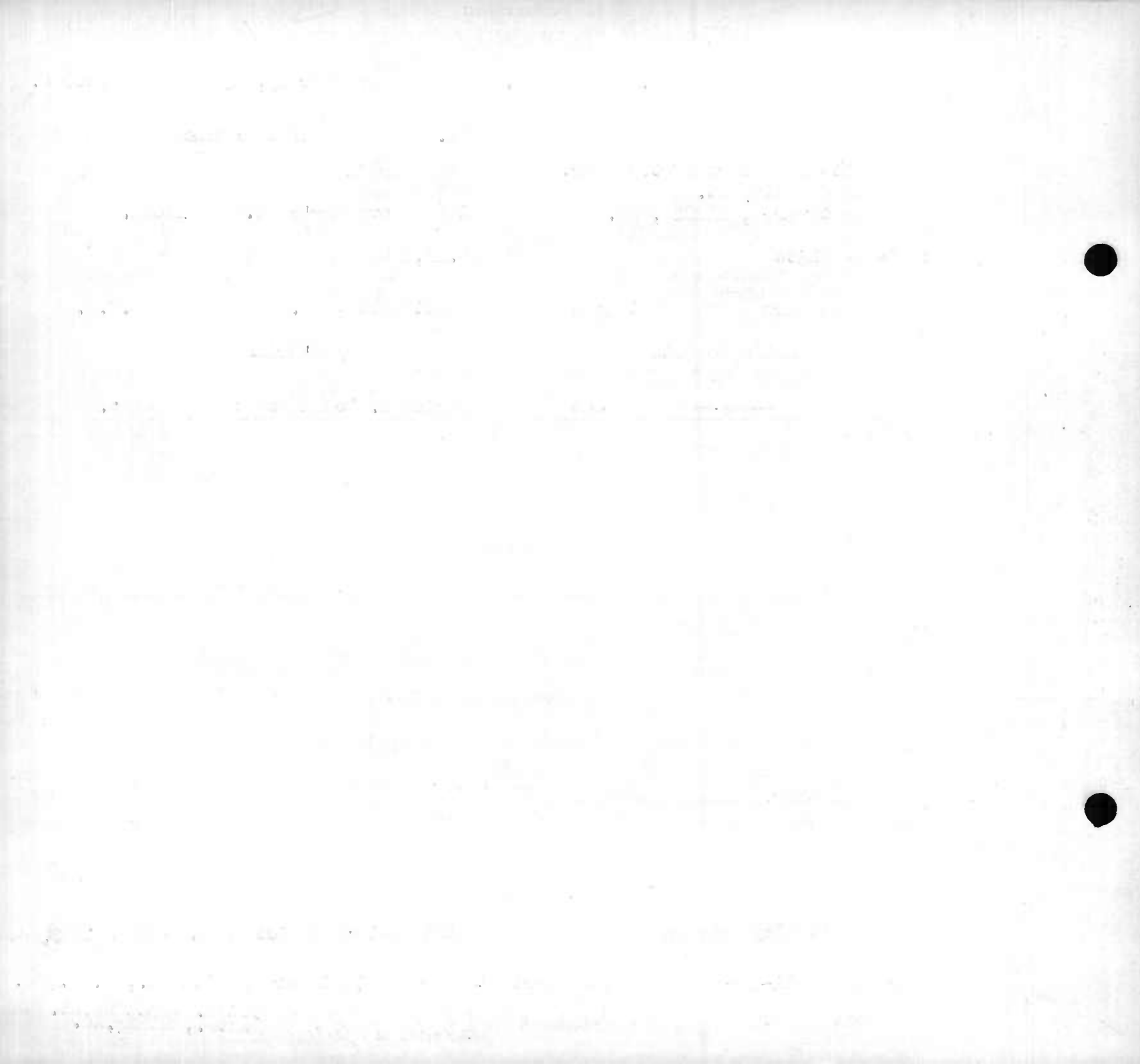
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11916 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

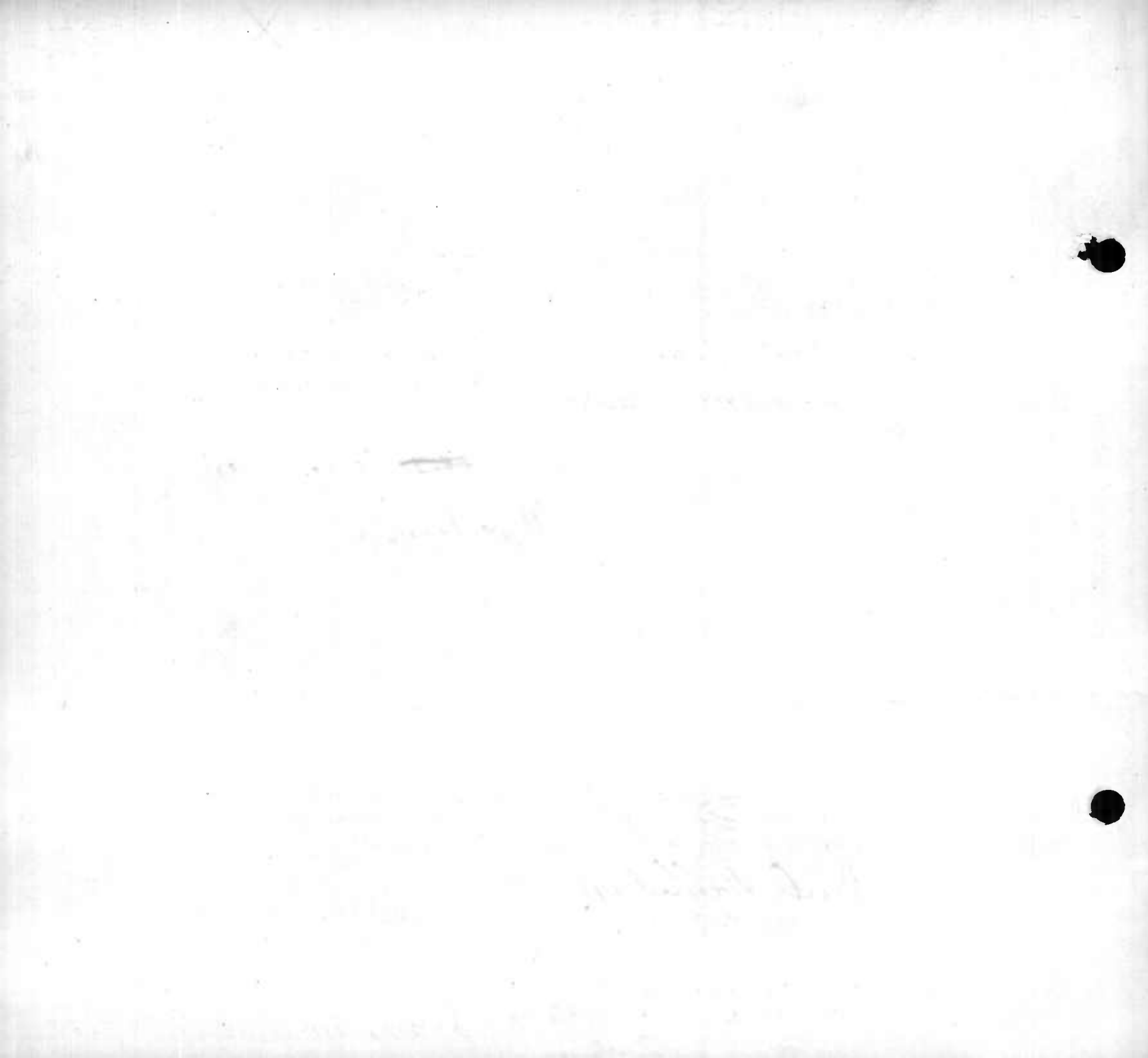
REG. NO. 68-11916

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARGARET A. BOCKLAGE		November 25, 1968 9:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Md. Anne Arundel Co 52-00	
90 Little Sisters of the Poor. 1200 Valley St. Baltimore, 21202, Md.				C. CITY OR TOWN Glen Burnie	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 106 D Governor's Ct. # 21061.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb. 11, 1908	60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House Work		At Home		Baltimore, Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Martin Roberts				Mary O'Brien	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Charles F. Bocklage : Same.	
18. CAUSE OF DEATH					
174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF: Co of the breast (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1968 to Nov 25 1968, that (I) (we) lost saw the deceased alive on Nov 25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Ankudas				23B. DATE SIGNED 11-26-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				1101 Maiden Choice Lane., Balto, 21228, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11-29-68		Sacred Heart Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				7401 German Hill Rd., Ba. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 29 1968		Robert E. Fulkerson		Charles J. Geiler	
				901 S. Conkling St. Balto., 21224, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-11917	
1. NAME OF DECEASED (Type or Print) <i>Theresa B. Howski</i>				2. DATE AND HOUR OF DEATH <i>11/23/68 11:00 P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND #21224</i>				C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>FEMALE</i> 6. RACE <i>WHITE</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>4-17-27</i>		9. AGE (In years last birthday) <i>41</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>				11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>WM. ZAJACZKOWSKI</i>				14. MOTHER'S MAIDEN NAME <i>TILLIE DEMSKI</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>218-22-9350</i>		17. INFORMANT ADDRESS <i>RECORDS: BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE #21224</i>	
18. <i>402X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>MI - Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION <i>443X II</i>				20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-19</i> <i>1968</i> to <i>11-23</i> <i>1968</i> , that (I) (we) last saw the deceased alive on <i>11-23</i> <i>1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Paul Kalkut M.D.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11-23-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>PAUL KALKUT M.D.</i>				23D. ADDRESS <i>BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE #21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11/27/1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>ST. STANISLAUS CEMETERY</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE M.D.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 29 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Tschuma</i>		25C. FUNERAL DIRECTOR <i>RAYMOND L. KACZOROWSKI</i>		ADDRESS <i>2525 FLEET ST.</i>	



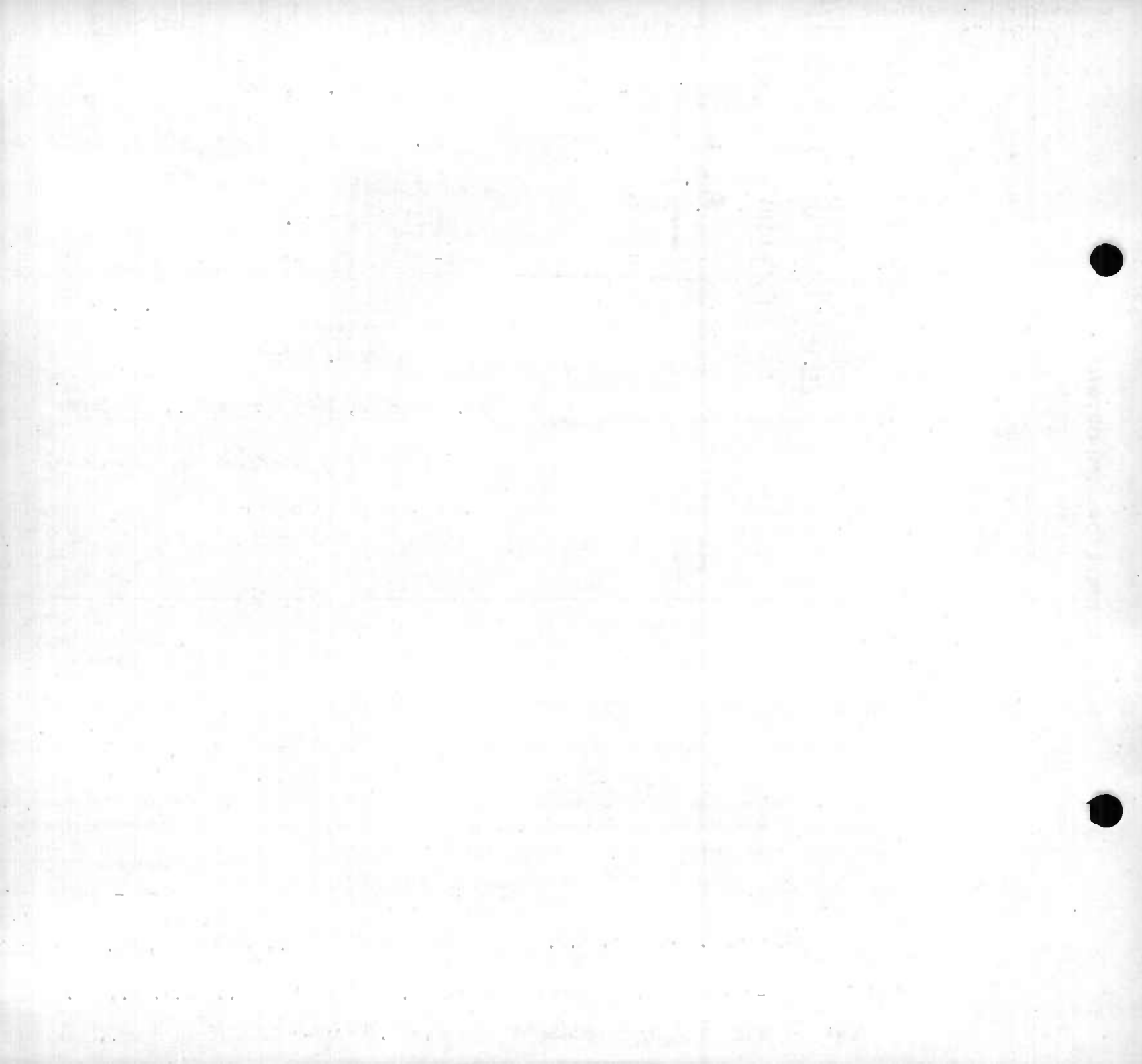
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11918 CERTIFICATE OF DEATH

REG. NO. 68-11918

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNA CATHERINE WARBUTTON		2. DATE AND HOUR OF DEATH Nov. 24, 1968 11:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 25-05		5. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1631 Spruce St. Baltimore, Md. 21226		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-11-1888		9. AGE (In years last birthday) 80		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME John F. Sachs		14. MOTHER'S MAIDEN NAME Anna C. Metz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Epsosito, 1629 Spruce St., Baltimore	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 410.91 CORONARY OCCLUSION		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE		(B) DUE TO, OR AS A CONSEQUENCE OF: 2 Years	
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 1967 19 to 11/24/68 19, that (I) (we) lost saw the deceased alive on 11/27/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Silvino B. Muneses				23B. DATE SIGNED 11-25-1968	
23C. PHYSICIAN'S NAME (Type) Silvino B. Muneses, M.D.				23D. ADDRESS 5010 Ritchie Hgwy., Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-27-68		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Pk.	
24D. LOCATION Ritchie Hgwy., A.A.Co., Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 29 1968		24F. NAME OF REGISTRAR Robert E. Johnson	
24G. FUNERAL DIRECTOR George J. Gorge		24H. ADDRESS 4001 Ritchie Hgwy., Baltimore		24I. DATE 11-27-68	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

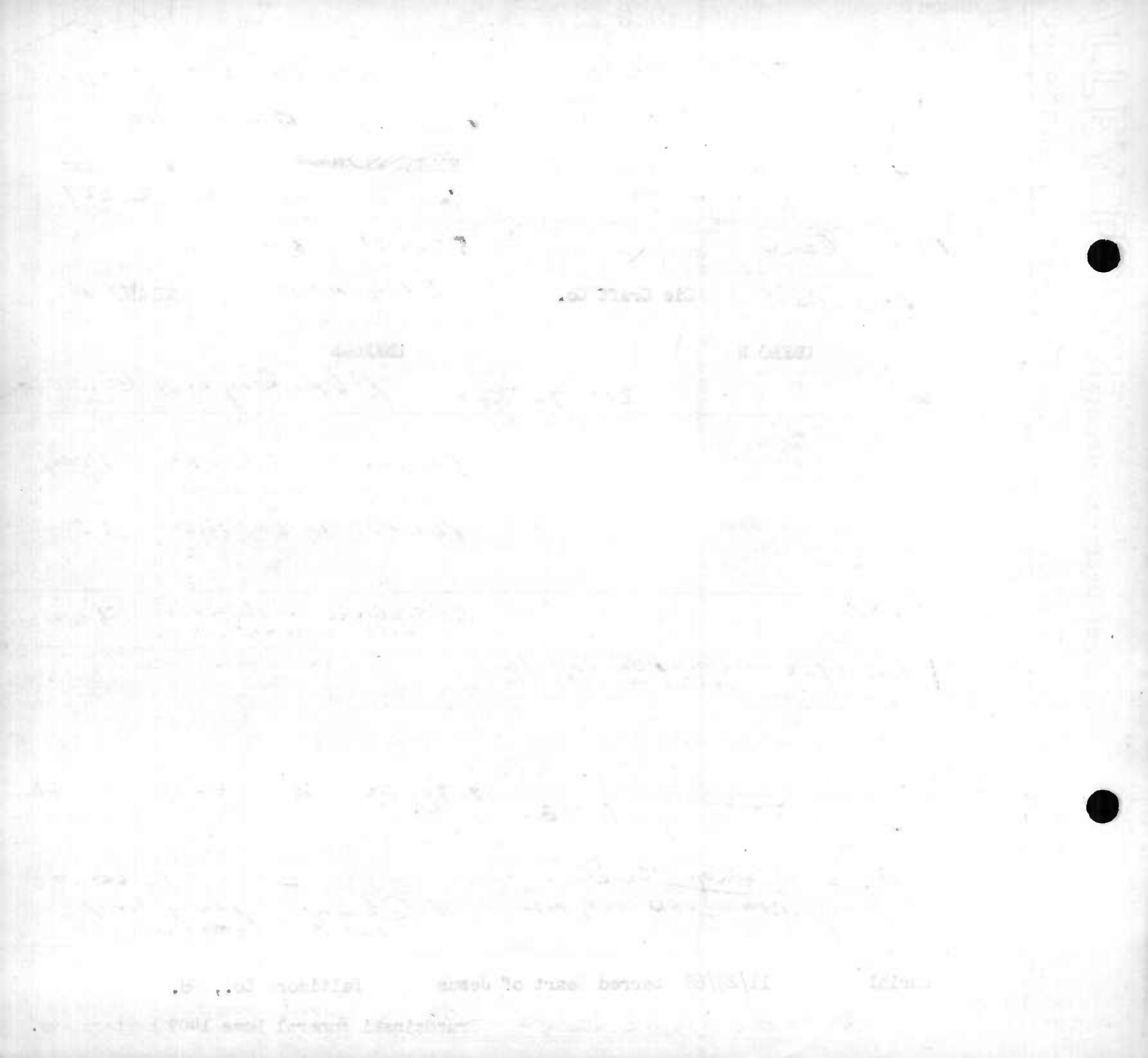
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11919
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Robert P. Moon</u>		2. DATE AND HOUR OF DEATH <u>11/25/68</u> <u>10:25 A.M.</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Anne Arundel Co</u> <u>52-00</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>		C. CITY OR TOWN <u>Elkview Burnie</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>Box 423. RT. #2</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07-12-1896</u>	9. AGE (In years lost birthday) <u>72</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert P. Moon</u>		
14. MOTHER'S MAIDEN NAME <u>Carrie B. Edwards</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>/</u>		
16. SOCIAL SECURITY NO. <u>217-07-6824</u>		17. INFORMANT <u>Mr. William Gunkel - 5520 Moore St., Baltimore</u>		
18. <u>150X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ca of esophagus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u>				
150X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>/</u>	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>/</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>/</u>		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>/</u>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>/</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>November 23rd 1968</u> to <u>November 25th 1968</u> , that (I) (we) lost saw the deceased alive on <u>November 25th 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Michael G. K...</u>		23B. DATE SIGNED <u>11/25/68</u>		23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>
23D. ADDRESS <u>DEGREE</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11-27-'68</u>	24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 29 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. ...</u>	25C. FUNERAL DIRECTOR ADDRESS <u>George J. Gonce, 4001 Ritchie Hgwy., Baltimore</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

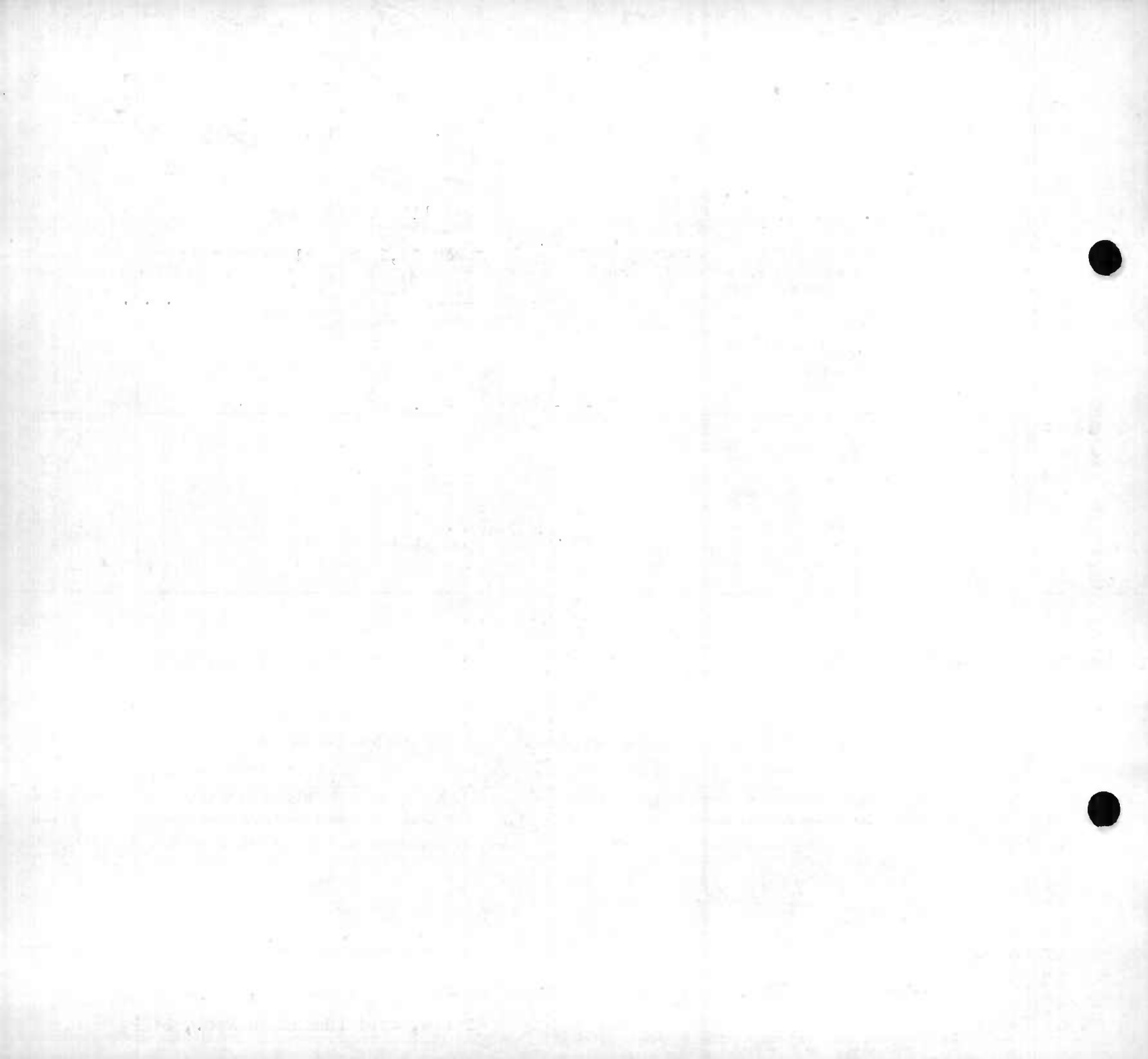
68-11920				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11920	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				JOHN REID		NOV. 26 - 1968 11-10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
CHURCH HOME HOSPITAL 35 100 N. BROADWAY ST.				Maryland BALTIMORE 53-00			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				ESSEX 21221		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				641 DUNWICH WAY 21221			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
Male	Cauc.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	5-23-01	67			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Assembler		Die Craft Co.		ENGLAND		ENGLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNKNOWN				UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		217-36-3903		P. Van Long md		Church Home Hosp.	
18. 569.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				PULMONARY EDEMA & CONGESTIVE FAILURE 1 day			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				PULMONARY Embolism 1 day			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. 578X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Septicemia & Bowel perforation 3 wks.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NOV. 2/68		Peritonitis & Bowel perforation					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 10-30-68 1968 to 11-26-1968, that (I) (we) last saw the deceased alive on 11-26-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
P. Van Long md				11-26-68			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
PHAM, VAN LONG MD				Church Home Hosp. 100 N. Broadway ST.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/29/68		Sacred Heart of Jesus		Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 29 1968		Robert E. Jankins		Prudzinski Funeral Home		1407 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-635		68-11921		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-11921	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Giordano, Joseph</u>				2. DATE AND HOUR OF DEATH <u>11-28-68</u> <u>12:30</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u> Md. </u> B. COUNTY <u> Balto. </u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Agnes Hospital</u> <u>10 Caton & Wilkens Ave.</u> <u>Balto. 21229</u>						C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER <u>1110 Cooks Lane</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 19, 1888</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Giordano</u>				14. MOTHER'S MAIDEN NAME <u>Frances</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>219-26-4247</u>		17. INFORMANT <u>Mrs. Serio (daughter)</u>		ADDRESS <u>same</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>EUA</u> (B) <u>ASCU</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCU</u> (C) <u>none</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>?</u>	
19A. DATE OF OPERATION <u>4-22-1</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>II</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 28 1966</u> to <u>Nov 28 1968</u> , that (I) (was) lost saw the deceased alive on <u>Nov 28 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Earl Pass</u> DEGREE						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>11-28-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Earl Pass</u>						23D. ADDRESS <u>4001 Wilkens Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/2/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Witzke, 4101 Edmondson Ave., 21229</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>J-525</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>68-11922</u>	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				<u>JENKINS, MRS. GENEVIEVE D.</u>		<u>11.27.68</u> <u>1.40 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
<u>BON SECOURS HOSPITAL</u>				<u>Md.</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				<u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location)			
				<u>1836 McHENRY ST.</u>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>11-2-06</u>	<u>62</u>	<u>PB X Operator</u>	<u>Md.</u>	<u>U.S.A.</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
<u>JAMES E. DONNELLY</u>			<u>MARY McGEHEAN</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		
			<u>215-10-3305</u>		<u>Miss Doris M. Jenkins, 416 Park Creek Rd</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
<u>180X I</u>			<u>RESPIRATORY FAILURE</u>				
<u>ANTECEDENT CAUSES</u>			<u>RECURRENT CARCINOMA PANCREAS</u>				
<u>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</u>			<u>Carcinoma, cervix</u>			<u>3 years</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<u>Cervical Chondrosarcoma</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>OCTOBER 28. 68</u>		<u>RECTO-VERSICAL FISTULA</u>		<u>Yes</u>		<u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>10.24.68</u> 19 to <u>11.27.68</u> 19, that (I) (we) last saw the deceased alive on <u>11.27.68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
<u>U. Sangkum</u>						<u>11.27.68</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
<u>U. SANGKUM</u>				<u>B.S.H.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/29/68</u>		<u>Meadowridge Cemetery</u>		<u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<u>NOV 29 1968</u>		<u>Robert E. Johnson</u>		<u>Witzke, 4101 Edmondson Ave.,</u>		<u>21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-263 68-11923				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 68-11923	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>MRS ROSE Heagerty</i>		2. DATE AND HOUR OF DEATH <i>11/26/68</i> <i>6 40 PM</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRO NOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i> <i>34</i>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <i>1332 Westburn Road</i>				5. SEX <i>Female</i> 6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>3/13/28</i> 9. AGE (In years last birthday) <i>40</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
13. FATHER'S NAME <i>John H. Kirtwood</i>				14. MOTHER'S MAIDEN NAME <i>Scheid</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>215-01-7861</i>				17. INFORMANT <i>Mrs. Harvey E. Spurrier, Jr., 1332 Westburn Rd</i>		ADDRESS	
18. <i>410.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiopulmonary arrest.</i>						<i>45 min.</i>	
(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i>						<i>12 hrs.</i>	
(C) <i>Arteriosclerotic Cardiovascular Disease</i>						<i>20 years.</i>	
19. DATE OF OPERATION <i>420.1</i> II				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <i>Nov - 26</i> <i>1968</i> to <i>Nov. 26</i> <i>1968</i> , that (I) (<u>we</u>) last saw the deceased alive on <i>Nov. 26</i> <i>1968</i> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.				23A. SIGNATURE <i>Jose G. Amayo</i> M.D. DEGREE		23B. DATE SIGNED <i>Nov. 26-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOSE G. AMAYO</i> M.D. DEGREE				23D. ADDRESS <i>Bon Secours Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>11/29/68</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>				24E. NAME OF REGISTRAR <i>Robert E. Jarkyns</i>		24F. FUNERAL DIRECTOR <i>Witzke, 4101 Edmondson Ave., 2 1229</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 29 1968</i>				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS				25E. ADDRESS		25F. ADDRESS	

F-656

68-11924 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11924

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) BARRY FARMER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 26 68 2:00 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour November 26, 1968 2:00 p. M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 53-00	
7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 7-22-1948	10. AGE (In years last birthday) 20 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 6025 Gwynn Oak Ave.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		13. FATHER'S NAME Howard Farmer	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Dorothy Eanes	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 218-52-1444	
18. INFORMANT Howard Farmer		ADDRESS 6025 Gwynn Oak Avenue #7	
19. E 925.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Electrocution (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME OF INJURY (APPROX.) Month (Day) (Year) (Hour) 11 26 68 1:06 p.m.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 927 Fordwood Ct. 53-00	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Live wire fell on line that subject was working on	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/27/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-29-68	
24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY BALTIMORE DEPT. NOV 29 1968		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Ellsworth Armacost		ADDRESS 4600 Liberty Hghts. Ave.	

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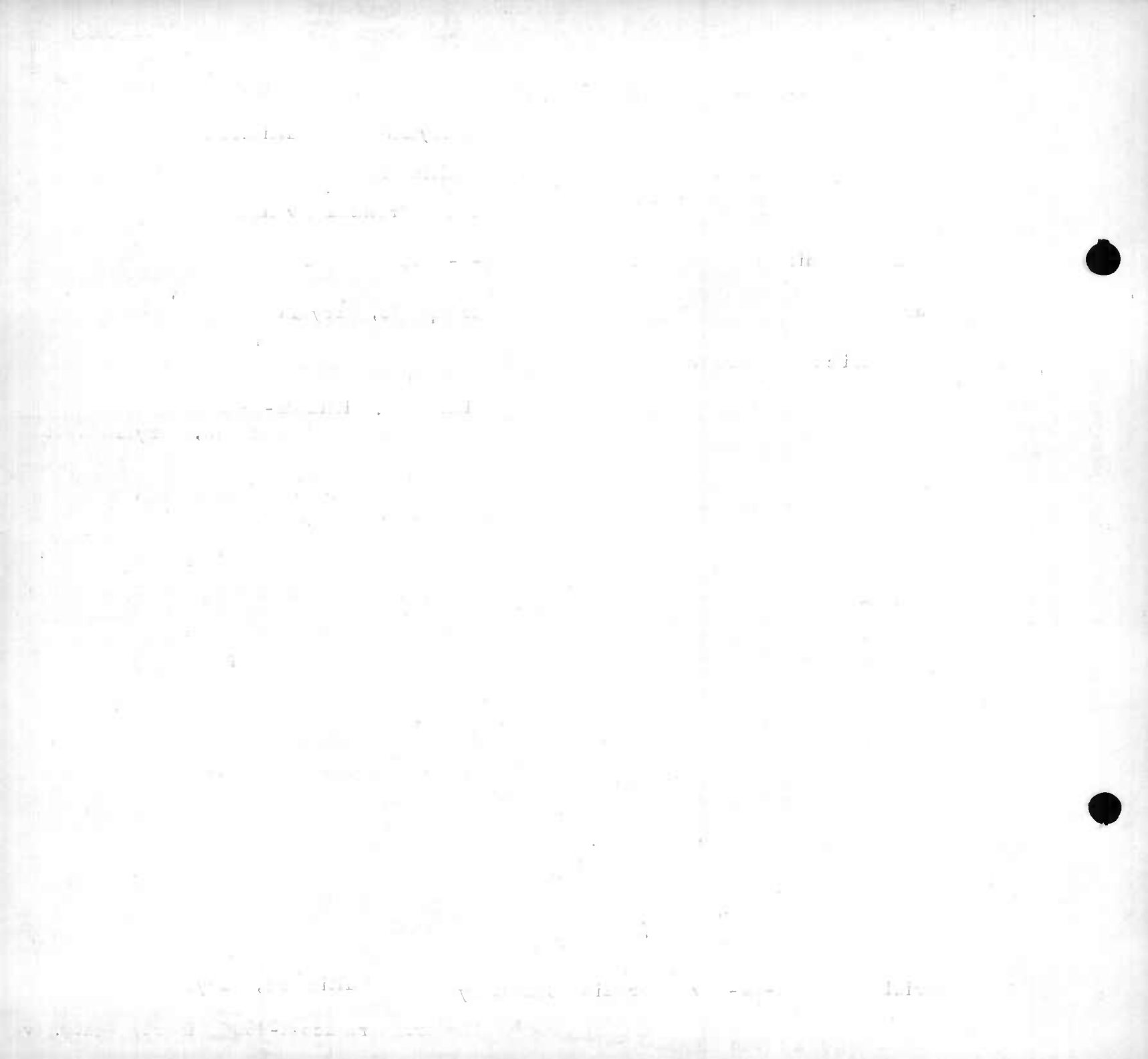
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11925 CERTIFICATE OF DEATH

REG. NO. 68-11925

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Alice Scarborough		2. DATE AND HOUR OF DEATH 11-27-68 10.30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Anderson Nursing Home		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 3814 Granada Avenue	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-1879	9. AGE (In years lost birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harford Co, Maryland	
13. FATHER'S NAME Patrick Kearney		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS William R. Williams - RD2 Box 320	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Anterior - Sclerotic Heart - 5 yrs.		CAUSE OF DEATH Aberdeen, Maryland		APPROXIMATE INTERVAL 2-1001	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.0 II		(B) Chronic Osteo - Arthritis - 2 yrs.		(C) Generalized Arterio Sclerosis	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 21 - 67 19 to 11/27 19 68 . that (I) (was) last saw the deceased alive on Nov 20 19 68 and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) view the body after death.					
23A. SIGNATURE Earl L. Chambers		23B. DATE SIGNED 11/27/68		23C. PHYSICIAN'S NAME (Type) Earl L. Chambers - M.D.	
23D. ADDRESS 4108 Liberty Hts. Baltimore		23E. DEGREE M.D.		23F. DEGREE M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-30-68		24C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery	
24D. LOCATION Baltimore, Maryland		24E. CITY, TOWN, OR COUNTY Baltimore		24F. STATE Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Ellsworth Armacost-4600 Liberty Hgts. Ave	



NON MED. DR. WILSON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>Montgomery Co. Md.</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>68-11926</u>
1. NAME OF DECEASED (Type or Print) <u>Richard Sexton</u>		2. DATE AND HOUR OF DEATH <u>11/22/68</u> <u>5 55</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>MONTGOMERY Co.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>		C. CITY OR TOWN <u>BOYDS</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>Rt # 1</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-8-68</u>	9. AGE (In years last birthday) <u>14</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				
13. FATHER'S NAME <u>GLENN O. SEXTON</u>		14. MOTHER'S MAIDEN NAME <u>EILEEN MUSICK</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Glenn Sexton, Boyds - Maryland</u>
18. <u>747.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Congenital Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>(Correlation +</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
18. <u>754.6</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>11/22/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Correlation of Aorta</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11/20</u> 19 <u>68</u> to <u>11/22</u> 19 <u>68</u> . that (I) (we) last saw the deceased alive on <u>11/22</u> 19 <u>68</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Howard C Swider Jr</u>		23B. DATE SIGNED <u>11/22/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>Howard C Swider, Jr, MD</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/25/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Monocacy</u>
24D. LOCATION (City, town, or county) (State) <u>Beallsville, Montgo. Md</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 29 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>William B. Hilton, Beallsville</u>

Y

Capital Asset Group
(Construction +)

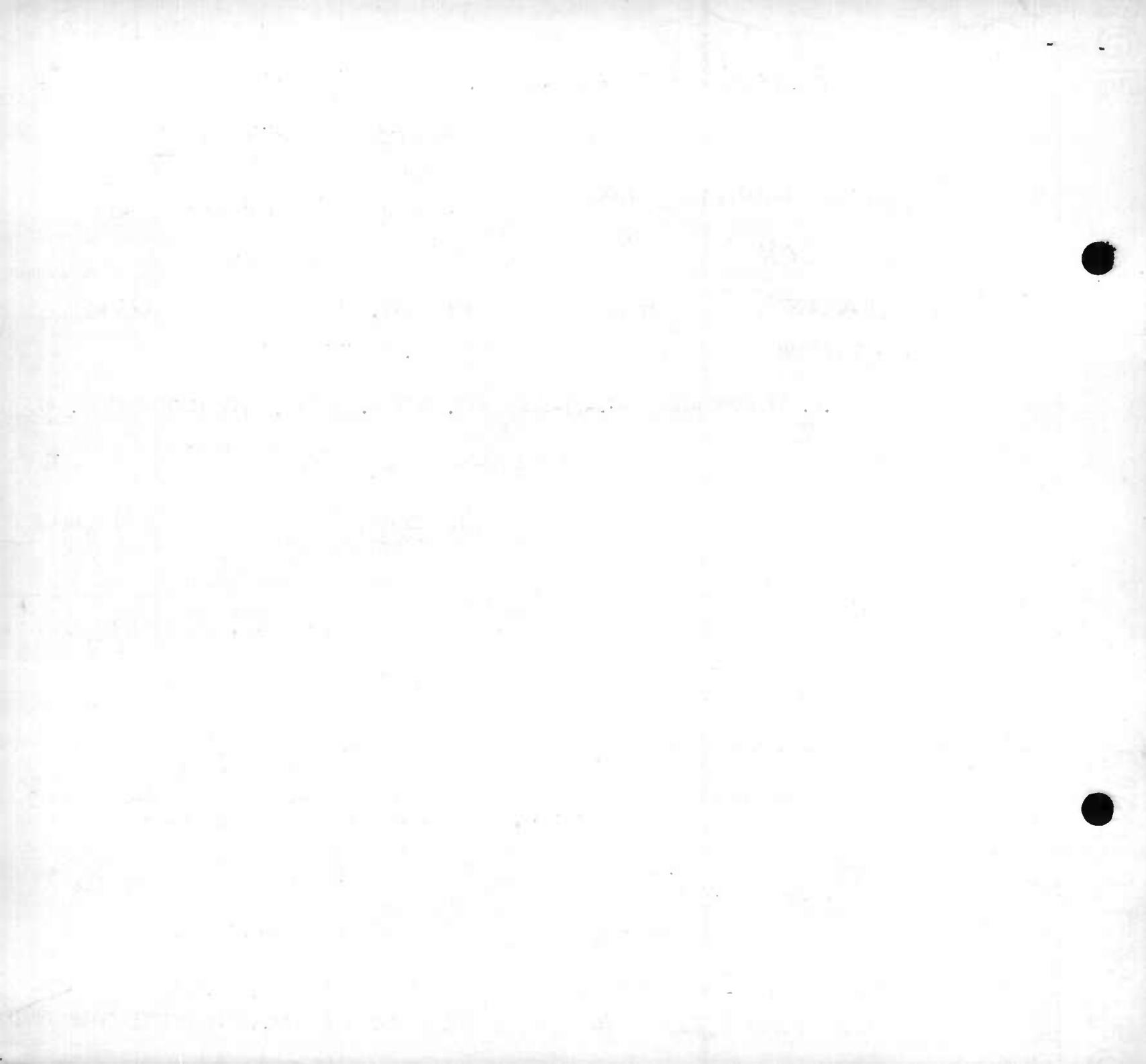
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11927</u>
68-11927		CERTIFICATE OF DEATH		
BIRTH NO. <u>55</u>				
1. NAME OF DECEASED (Type or Print) <u>BERMAN, THEODORE B.</u>		2. DATE AND HOUR OF DEATH <u>11/26/68</u> <u>3:45</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI HOSPITAL, INC.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6713 WESTBROOK RD</u>		
5. SEX <u>MALE</u>	6. RACE <u>CAU.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/09</u>	9. AGE (In years lost birthday) <u>59</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT LAW</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>MEYER BERMAN</u>		
14. MOTHER'S MAIDEN NAME <u>R. MINNIE ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W. 11 ARMY AIR FORCE</u>		
16. SOCIAL SECURITY NO. <u>212-01-3084</u>		17. INFORMANT <u>MRS. RUTH G. BERMAN, 6713 WESTBROOK RD. #15</u>		
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>myocardial infarction</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CVA</u> (B) <u>ASEVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>14 years</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>10/19</u> 19 <u>68</u> to <u>11/26</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/26</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Eric Judity</u>		23B. DATE SIGNED <u>11/26/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>ERIC JUDITY</u>		23D. ADDRESS <u>SINAI HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-28-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE HEBREW</u>
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 29 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11928	
BIRTH NO. ELIZABETH 68-11928 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Betty Hartzell			2. DATE AND HOUR OF DEATH 2 45 PM 11-24-68		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN Towson D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Md. Gen. Hosp.			E. STREET AND NUMBER 632 Round Oak Rd.		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-11	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY @ home		11. BIRTHPLACE (State or foreign country) Jacksonville, Florida	
13. FATHER'S NAME R. Larner Davidson			14. MOTHER'S MAIDEN NAME Mabel Pierce		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Hospital I. D. Shedd		
18. I 174X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Carcinoma of breast			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 170X II					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/17 to 11/24 1968 that (I) (we) last saw the deceased alive on 11/24 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.					
23A. SIGNATURE MARVIN C. JACHTS				23B. DATE SIGNED 11-24-68	
23C. PHYSICIAN'S NAME (Type) MARVIN C. JACHTS				23D. ADDRESS Md. Gen. Hosp	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 11/27/68		24B. DATE NOV 29 1968		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley	
24D. LOCATION (City, town, or county) (State) Towson, Md		25A. DATE REC'D BY HEALTH DEPT. NOV 29 1968			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Rudolph A. Baranco, Severna Park			

Handwritten notes:

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

[illegible]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11929

BIRTH NO.

REG. NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
MARY A. MAISCH | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> 11 22 68
Hour 6:55p M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
836 Edmondson Ave. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
November 22, 1968 6:55 p.m. | |
| 6. SEX
Female | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 17-23 | |
| 9. DATE OF BIRTH
9/3/1873 | | 10. AGE (In years last birthday) 95
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Balto., Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 17. SOCIAL SECURITY NO.
213-12-1490 | |
| 18. INFORMANT
Miss Irene C. Maisch | | ADDRESS
836 Edmondson Ave. | |
| 19. 412.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION
11/22/68 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Edward F. Wilson M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED Nov. 23, 1968 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
11/26/68 | |
| 24C. NAME OF CEMETERY or CREMATORY
Druid Ridge Cem. | | 24D. LOCATION (City, town, or county) (State)
Bkessville | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
NOV 29 1968 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | |
| 25C. FUNERAL DIRECTOR
Wm J. Tichner | | ADDRESS
Seaw Balto, Md. | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>68-11930</u> | |
|---|------------------------|--|---|--|--|
| BIRTH NO. <u>68-11930</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. <u>1</u> | | | 2. DATE AND HOUR OF DEATH <u>11/27/68</u> <u>4:05</u> M. | | |
| 1. NAME OF DECEASED (Type or Print) <u>LEE, Robert</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>THE JOHNS HOPKINS HOSPITAL</u> | | | A. STATE <u>MARYLAND</u>
B. COUNTY <u>BALTIMORE</u> | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | INSIDE CITY LIMITS | | |
| D. STREET ADDRESS (If rural, give location)
<u>3025 HANLON AVE</u> | | | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>COLORED</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>1-25-11</u> | 9. AGE (In years lost birthday) <u>57</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Loader</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Bethlehem Steel</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Bethune, S.C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME
<u>CHARLES LEE</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARY ABEL</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>218/01/8827</u> | | 17. INFORMANT ADDRESS
<u>Mrs. Roaie, Lee, 3025 Hanlon Ave.</u> | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>PNEUMONIA</u>
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>ASPIRATION</u>
<u>HODGKIN'S DISEASE</u> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>201X II</u> | | | | | |
| 19A. DATE OF OPERATION
<u>NONE</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>NONE</u> | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<u>NONE</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) <u>the physician</u> attended the deceased from <u>OCT. 28</u> 19 <u>68</u> to <u>NOV. 27</u> 19 <u>68</u> , that (1) <u>last</u> saw the deceased alive on <u>NOV. 27</u> 19 <u>68</u> and that in (my) <u>apinian</u> death occurred on the date and hour and from the causes stated above. (1) <u>the</u> did <u>not</u> view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Seymour Levine</u> M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
<u>Nov 27, 1968</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>SEYMOUR LEVINE</u> | | 23D. ADDRESS
<u>JOHNS HOPKINS HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>12/2/68</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Baltimore National</u> | |
| 24D. LOCATION (City, town, or county)
<u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>NOV 29 1968</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Feltz</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Charles R. Law, 802 Madison Ave.</u> | |

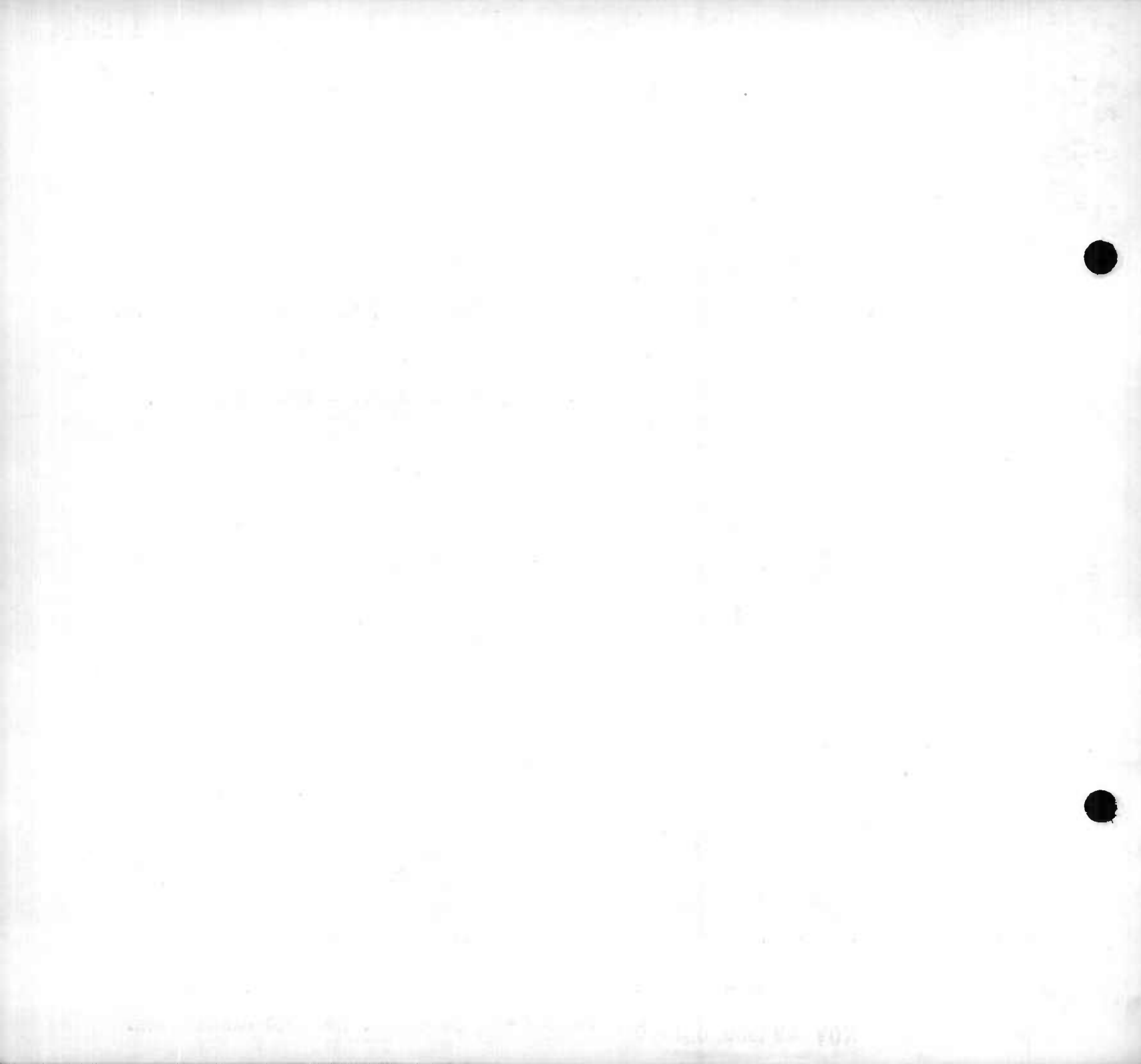
3/11/69 - Md. Veterans Commission World Ward II Vol. Serial Number: 33896733.

L. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| ELLA C. HOLMES | | 11-27-68 2:15 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | A. STATE
MARYLAND
B. COUNTY
BALTIMORE CITY | |
| 5. SEX
FEMALE | | 6. RACE
NEGRO | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | | 8. DATE OF BIRTH
9-18-96 | |
| 9. AGE (In years lost birthday)
72 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | |
| 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
PHILIP BROWN | | 14. MOTHER'S MAIDEN NAME
ELLEN HALL | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
213-05-6821-8 | |
| 17. INFORMANT
HAROLD HOLMES - 4002 WABASH AVE. | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Multiple Pulmonary Emboli | | INTERVAL BETWEEN ONSET AND DEATH
4 wks | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Deep vein thrombophlebitis | | DUE TO
? | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus & D. tropathy | | ? | |
| 19A. DATE OF OPERATION
4/22/11 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
II | |
| 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
- | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
- | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
- | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
- | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
- | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/16 to 11/27 19 68 that (I) (we) last saw the deceased alive on 11/26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Edward Jacobs | | 23B. DATE SIGNED
11/27/68 | |
| 23C. PHYSICIAN'S NAME (Type)
EDWARD JACOBS | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
11-29-68 | |
| 24C. NAME of CEMETERY or CREMATORY
BALTIMORE NATIONAL | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 29 1968 | | 25B. NAME OF REGISTRAR
Robert E. Jacobs | |
| 25C. FUNERAL DIRECTOR
CHARLES R. LAW | | ADDRESS
802 MADISON AVE. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11932

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11932

| | | | | | |
|--|---------------------|--|------------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Otto Blanchard</u> | | 2. DATE AND HOUR OF DEATH
<u>11/24/68</u> <u>3 A</u> (M.) | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>14-02</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>38 University Hospital</u> | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
<u>1401 Madison Ave</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7/24/08</u> | 9. AGE (In years last birthday)
<u>60</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Cook</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Elizabeth City, N. C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>Harvey Blanchard</u> | | 14. MOTHER'S MAIDEN NAME
<u>Florida Mann</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>216-05-3427</u> | | 17. INFORMANT ADDRESS
<u>Edward G. Blanchard - 1401 Madison Ave.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>5-24-9</u> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Hepatic Coma</u>
(B) <u>Obstructive Jaundice</u>
(C) <u>Cholelithiasis</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>48 hrs.</u>
<u>1-2 mos.</u>
<u>unknown</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,
<u>584X II</u> | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> 19 <u>68</u> to <u>11/24</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>11/28</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Gary M. Lathin</u> | | 23B. DATE SIGNED
<u>11/24/68</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>Gary M. Lathin</u> | |
| 23D. ADDRESS
<u>University Hospital Baltimore</u> | | 23E. DATE REC'D BY HEALTH DEPT.
<u>NOV 29 1968</u> | | 23F. NAME OF REGISTRAR
<u>Robert E. Jenkins</u> | |
| 23G. DATE REC'D BY HEALTH DEPT. | | 23H. NAME OF REGISTRAR | | 23I. FUNERAL DIRECTOR ADDRESS
<u>Charles R. Law 802 Madison Ave.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>12-2-68</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Mt. Auburn</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |



68-11933 CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

2. DATE AND HOUR OF DEATH

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MARYLAND ANNE ARUNDEL

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

GENERAL DELIVERY, GLEN BURNIE, MD.

5. SEX

6. RACE

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years lost birthday)

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

MALE

NEGRO

WIDOWED ☐DIVORCED ☐

2-23-1911

57

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

TRUCK DRIVER

MARYLAND

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

CLINTON HOWARD

MAMMIE WARREN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

212-18-2574

BCH: RECORDS

BALTIMORE CITY HOSPITALS

4940 EASTERN AVE.

BALTIMORE, MARYLAND 21224

18. 011.9 + 1303.9
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work ☐Not While At Work ☐

22. I certify that (this hospital) attended the deceased from Nov 21 19 68 to Nov 26 19 68, that (we) last saw the deceased alive on Nov 26 19 68 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) view the body after death.

23A. SIGNATURE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

BALTIMORE CITY HOSPITALS 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

11-30-68

MT. AUBURN

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 29 1968

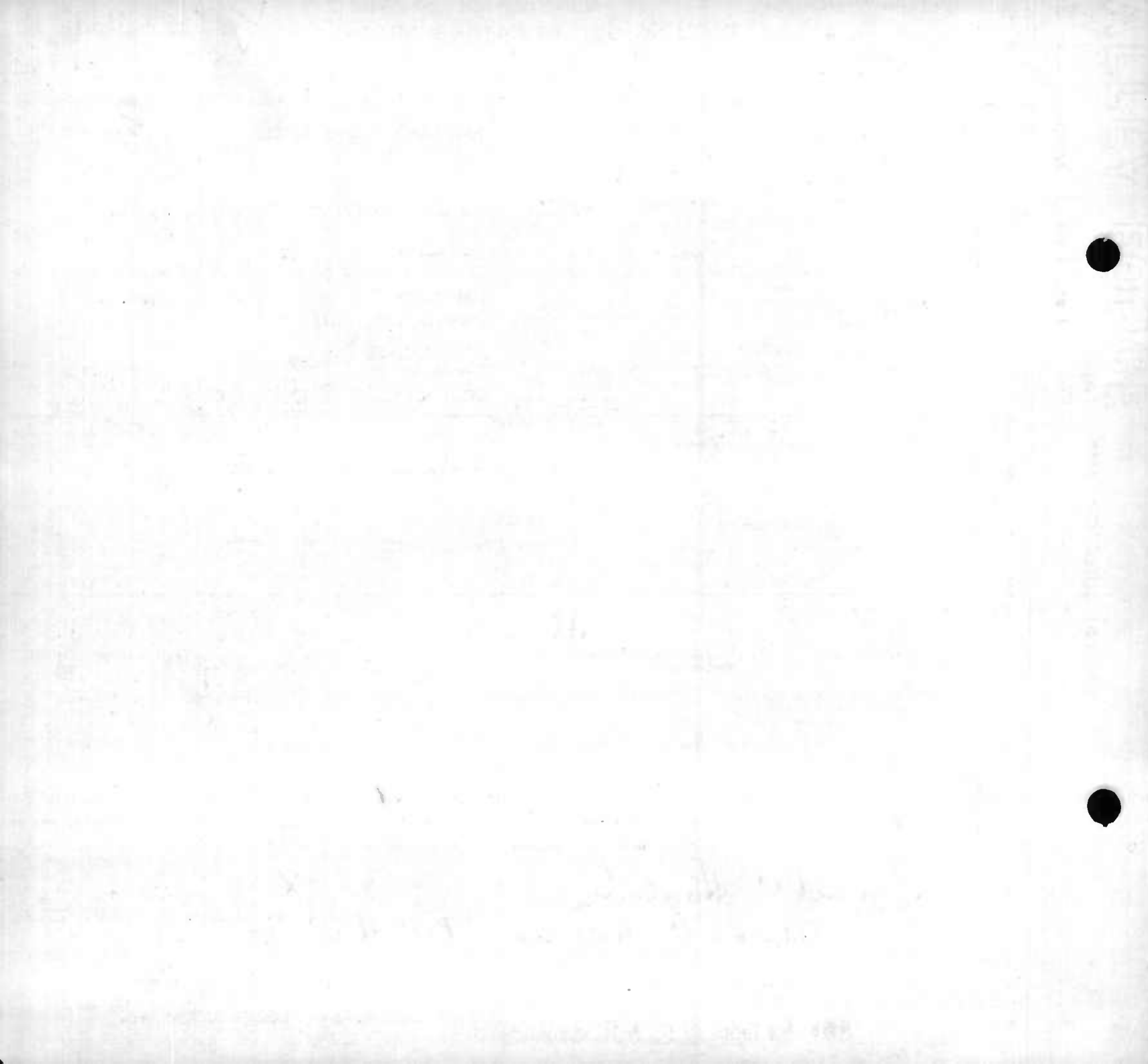
Robert E. Johnson

CHARLES R. LAW

802 MADISON AVE.

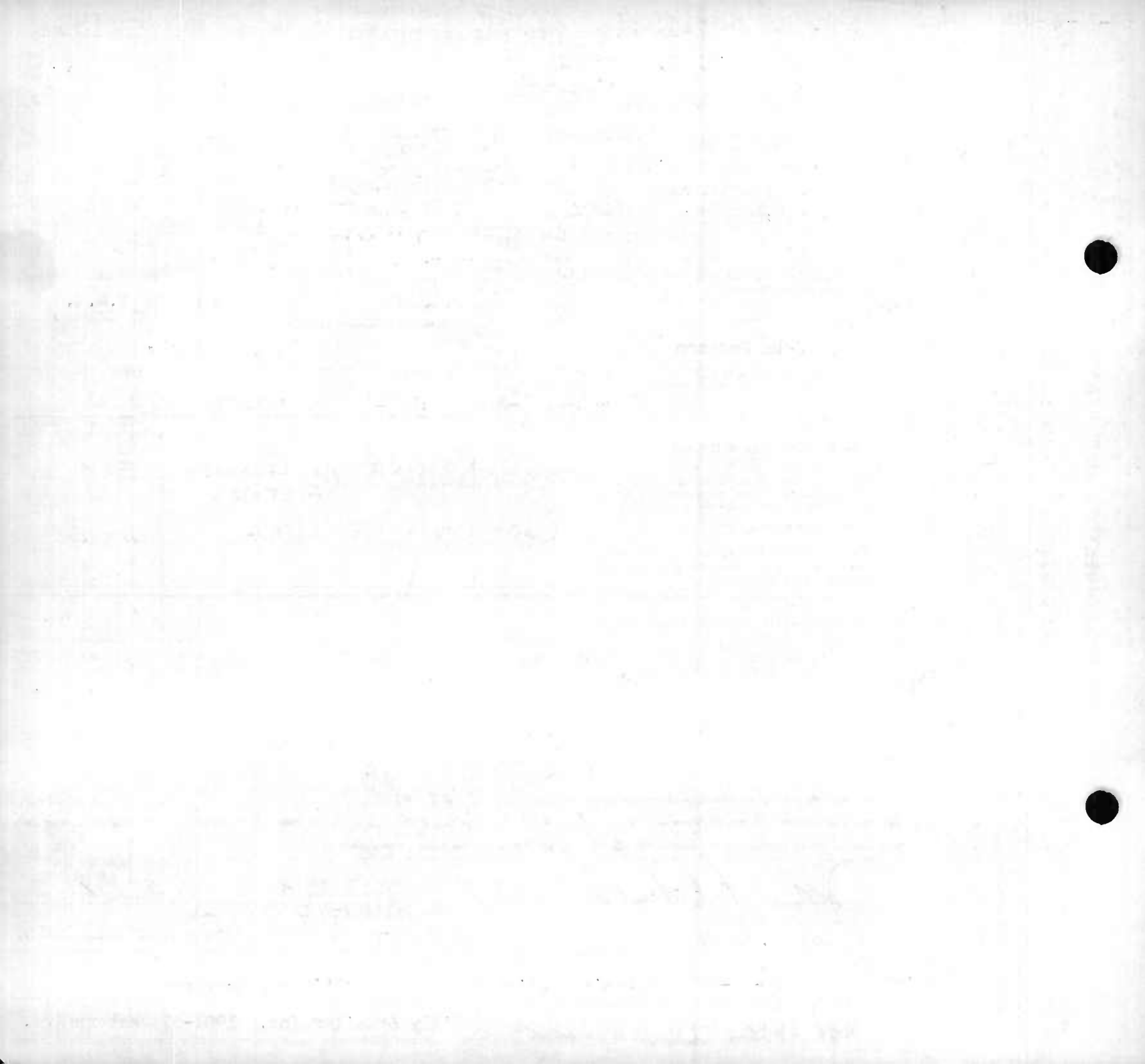
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 68-11934 | |
|--|--|--|--|
| BIRTH NO. P-625 | | 68-11934 | |
| 1. NAME OF DECEASED (Type or Print) HUGO L. PERSSON | | 2. DATE AND HOUR OF DEATH 11/27/68 8 ³⁰ A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD PERRSON, Hugo Leander | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-18-1893 9. AGE (In years last birthday) 75 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 11. BIRTHPLACE (State or foreign country) Sweden | |
| 13. FATHER'S NAME John Persson | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-07-4171-Records: BCH-4940 Eastern Avenue 21224 | |
| 17. INFORMANT ADDRESS | | 18. CAUSE OF DEATH | |
| 19. MEDICAL CERTIFICATION | | 19A. DATE OF OPERATION None 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NA 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NA 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NA 21C. WHERE DID INJURY OCCUR? NA | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) NA 21E. INJURY OCCURRED While At <input type="checkbox"/> NA Not While At Work <input type="checkbox"/> NA 21F. HOW DID INJURY OCCUR? NA | |
| 22. I certify that (this hospital) attended the deceased from 9/27/68 to 11/27/68 that (we) last saw the deceased alive on 11/27/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE John L. Cohen 23B. DATE SIGNED 11/27/68 | |
| 23C. PHYSICIAN'S NAME (Type) John L. Cohen | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL Burial | | 24B. DATE 11-30-1968 24C. NAME OF CEMETERY or CREMATORY Bohemian National 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 29 1968 | | 25B. NAME OF REGISTRAR Robert E. Finkbeiner 25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave. | |



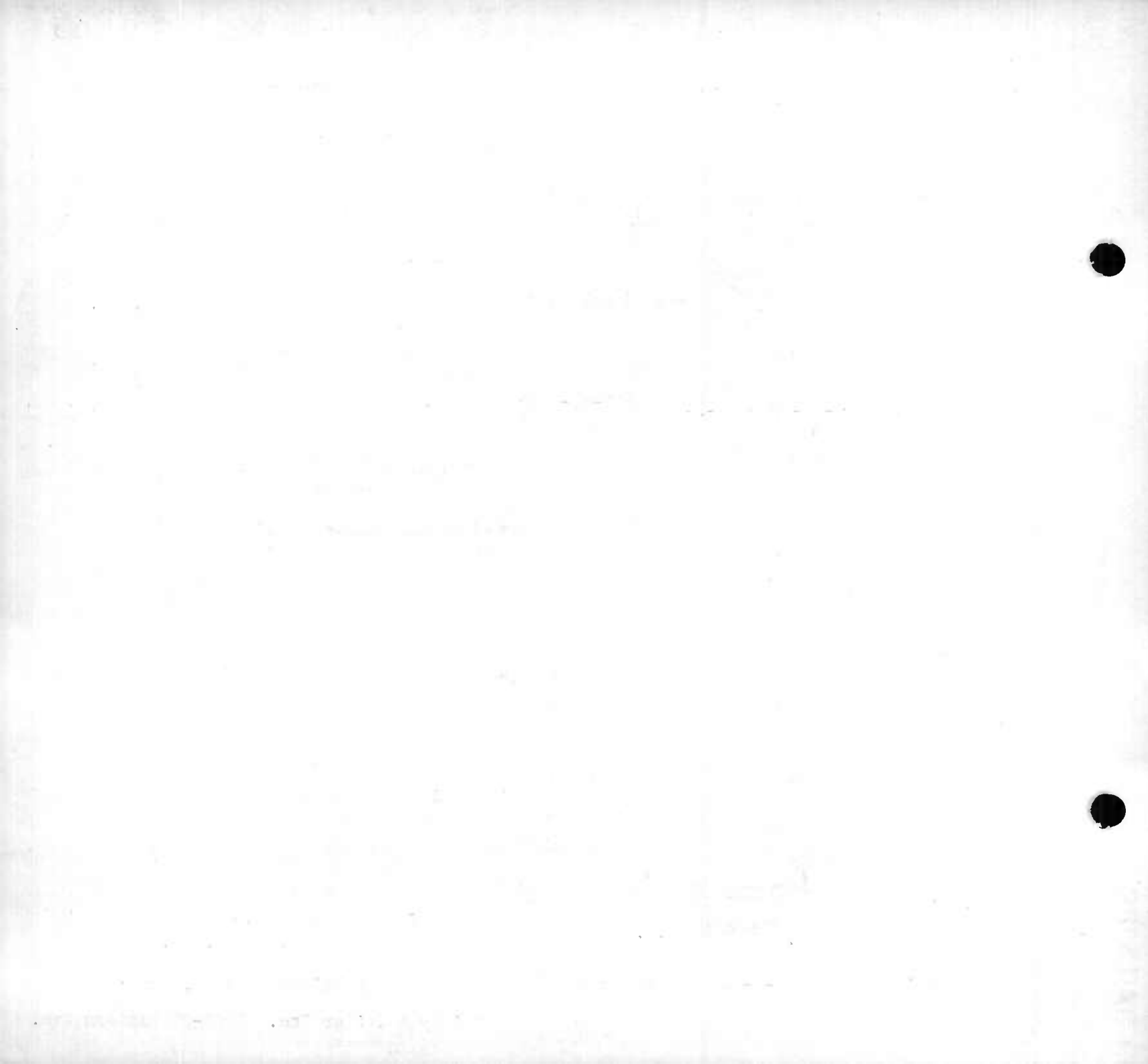
53-10-11

djs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 68-11935 |
|--|---------|--|------------------|--|--|
| BIRTH NO. | | 68-11935 | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| OBERLE, JOHN VINCENT | | 11-27-68 12:20P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | | |
| BALTIMORE CITY HOSPITALS | | MARYLAND BALTIMORE CO 53-00 | | | |
| 31 4940 EASTERN AVENUE | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | | | |
| BALTIMORE, MARYLAND 21224 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| E. STREET AND NUMBER | | 7323 BRIDGEWOOD DRIVE 21224 | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. AGE (If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.) |
| MALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 12-31-21 | 46 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| INSPECTOR | | Armco Steel | | MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? | | U.S.A. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| IRVIN OBERLE | | MARGARET KEARNEY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes 9-30-42 to 5-4-46 | | 217-14-0083 | | 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>fatal intracerebral aneurysm</i> | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertension and diabetes</i> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | | |
| 331X II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 3 11/25/68 | | INTRACEREBRAL HEMATOMA | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/26 1968 to 11/27 1968, that (I) (we) last saw the deceased alive on 11/27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| F. BACCI M.D. | | 11/27/68 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| F. BACCI | | BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO. MD. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12-2-1968 | | Oak Lawn | |
| 24D. LOCATION | | 24E. DATE REC'D BY HEALTH DEPT. | | | |
| Baltimore County, Maryland | | NOV 29 1968 | | | |
| 25A. NAME OF REGISTRAR | | 25B. FUNERAL DIRECTOR | | 25C. ADDRESS | |
| Lilly & Zeiler Inc. | | 1901-07 Eastern Ave. | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11936

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)A.
CHESTER KALACZYNSKI2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

November 27, 1968

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home and Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 27, 1968

10:10 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Aug. 3, 1926

10. AGE (In years
lost birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

503 South Belnord Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

Adam Kalaczynski

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Stella Forszak

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes or unknown) (If yes, give date of service)

Yes

8-12-43 to 2-17-46

17. SOCIAL SECURITY NO.

212-20-4378

18. INFORMANT

ADDRESS

Mrs. Margaret Kalaczynski 101 N. Montford Ave

19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxiation, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

Intestinal obstruction

DUE TO, OR AS A CONSEQUENCE OF:

(B)

Fibrous peritoneal adhesions

DUE TO, OR AS A CONSEQUENCE OF:

(C)

20. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 28, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-3-1968

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 29 1968

Robert E. Jenkins

Lilly & Zeiler Inc. 1901-07 Eastern Ave.

H-536

68-11937

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11937

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
LILLIAN M. HUNTER | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> 11 23 68
Hour 8:13 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
33 Johns Hopkins Hospital | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
November 23, 1968 8:13 p.m. | |
| 6. SEX
Female | | 7. RACE
Colored | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
MAY 13, 1912 | | 10. AGE (In years lost b'g)
56 | |
| 11. BIRTHPLACE (State or foreign country)
ROBERTSON Co. N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 15. MOTHER'S MAIDEN NAME
HATTIE DAVIS | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 17. SOCIAL SECURITY NO.
— | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
412.4
Arteriosclerotic cardiovascular disease | | 20. DATE OF OPERATION
21 | |
| 21. AUTOPSY? (Yes or No)
YES | | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| 24. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/28/68 | |
| 24C. NAME OF CEMETERY or CREMATORY
MT ARBORN CEM. | | 24D. LOCATION (City, town, or county) (State)
WESTPORT MARYLAND | |
| 25A. DATE RECEIVED
NOV 29 1968 | | 25B. NAME OF REGISTRAR
Robert E. [illegible] | |
| 25C. FUNERAL DIRECTOR
DONALD E. GLOVER | | 25D. ADDRESS
176 N. PATTERSON PARK AVE | |

24

1/2 lbs of butter
 1/2 lbs of sugar
 1/2 lbs of flour
 1/2 lbs of eggs
 1/2 lbs of milk
 1/2 lbs of cream
 1/2 lbs of vanilla
 1/2 lbs of salt
 1/2 lbs of baking powder
 1/2 lbs of baking soda
 1/2 lbs of yeast
 1/2 lbs of hops
 1/2 lbs of malt
 1/2 lbs of water
 1/2 lbs of fire
 1/2 lbs of air
 1/2 lbs of earth
 1/2 lbs of heaven
 1/2 lbs of hell
 1/2 lbs of everything
 1/2 lbs of nothing

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11938 CERTIFICATE OF DEATH

REG. NO. **68-11938**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Waddie Jean Butler

2. DATE AND HOUR OF DEATH

Nov. 25, 1968

3: 10 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

US Public Health Service Hospital
3100 Wyman Park Drive

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Pa.

C. CITY OR TOWN

Harrisburg

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

1735 N. Sixth St.

5. SEX

F

6. RACE

Col

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12/8/35

9. AGE (In years
last birthday)

33

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

? (prisoner)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ga.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Eugene Butler

14. MOTHER'S MAIDEN NAME

Corrie(Weems)

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18. 011.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Massive hemoptysis

Minutes

(B) DUE TO, OR AS A CONSEQUENCE OF:

Pulmonary granulomatous cavitation,
tuberculosis suspected

Months

(C).....

002.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct. 31 19 68 to Nov. 25 19 68,
that (I) (we) lost saw the deceased alive on Nov. 25 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William L. Wilkie MD

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

11/26/68

23C. PHYSICIAN'S
NAME (Type)

William L. Wilkie, Surgeon (R)

DEGREE

23D. ADDRESS

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

12-4-68

24C. NAME OF CEMETERY or CREMATORY

Wm. Howard Day Cemetery Steelton, Pennsylvania

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 29 1968

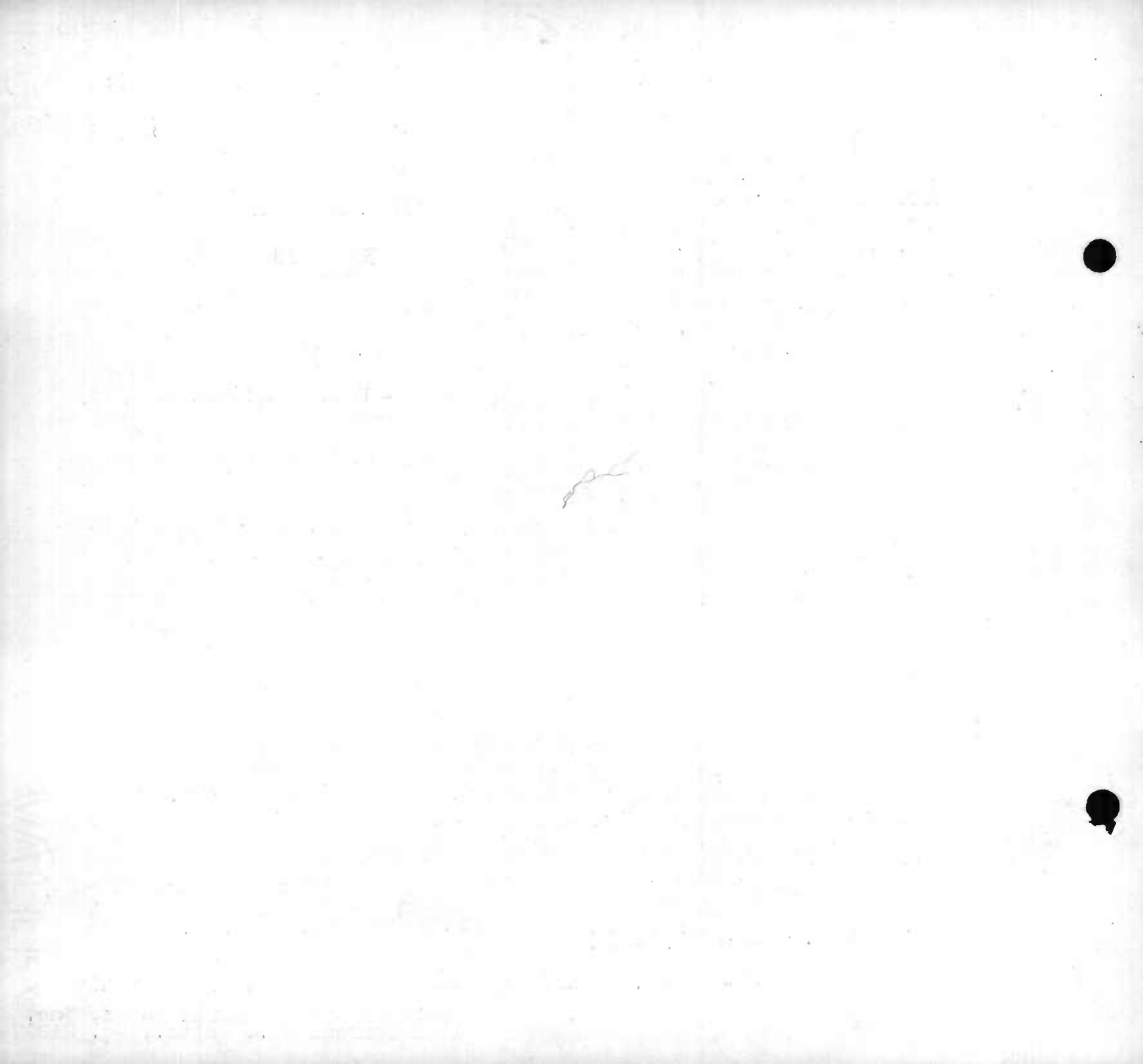
25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

Morton & Dyett Funeral Homes, Inc.
1701 Laurens St., Balto., Md. 21217

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11939 CERTIFICATE OF DEATH

REG. NO.

68-11939

| | | | | | |
|--|---------------------|---|---|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Donald Barksdale | | 2. DATE AND HOUR OF DEATH
11/27/68 11:50 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE MD. B. COUNTY 15-09 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
38 University Hospital | | | C. CITY OR TOWN
Ba/to | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
4006 Fairview Ave. | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6-3-33 | 9. AGE (In years lost birthday) 35 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
paper hanger | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MD. | |
| 13. FATHER'S NAME
Robert Barksdak | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
30-09208-320 | | 17. INFORMANT | |
| | | | | ADDRESS | |
| 18. 303.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
malabsorption | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 mos. | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Abdominal Fistulae | | | DUE TO, OR AS A CONSEQUENCE OF:
4 mos. | | |
| | | | (C) Alcoholism | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
322.2 II | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/24 19 68 to 11/27 19 68 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 11/27 19 68 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Gary M. Lattin | | | | 23B. DATE SIGNED
11/27/68 | |
| 23C. PHYSICIAN'S NAME (Type)
GARY M. LATTIN | | | | 23D. ADDRESS
University Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12-1-68 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Mem. Park Baltimore, Maryland | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
NOV 29 1968 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
2 Markon & Dgett Felt. 1701 Laurens | |



68-11940

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11940

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOHN TYLER

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

11

28

68

8:35 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

St. Agnes Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 28, 1968

8:35 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1/23/55

10. AGE (In years
last birthday)

13

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

229 S. Hilton St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Tyler

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lottie Cornish

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

none

18. INFORMANT

ADDRESS

Charles Tyler 229 S. Hilton St.

19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH(A) IMMEDIATE CAUSE Craniocerebral injuries
DUE TO, OR AS A CONSEQUENCE OF:(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Street

Hilton St. 204 ft. S. of Leed St.

22D. TIME
OF INJURY
(APPROX.)

11

26

68

3:00p

22E. INJURY OCCURRED
WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/3/68

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial pk

24D. LOCATION

(City, town, or county)

(State)

Arbutus, Maryland

25A. DATE REC'D BY HEALTH DEPT.

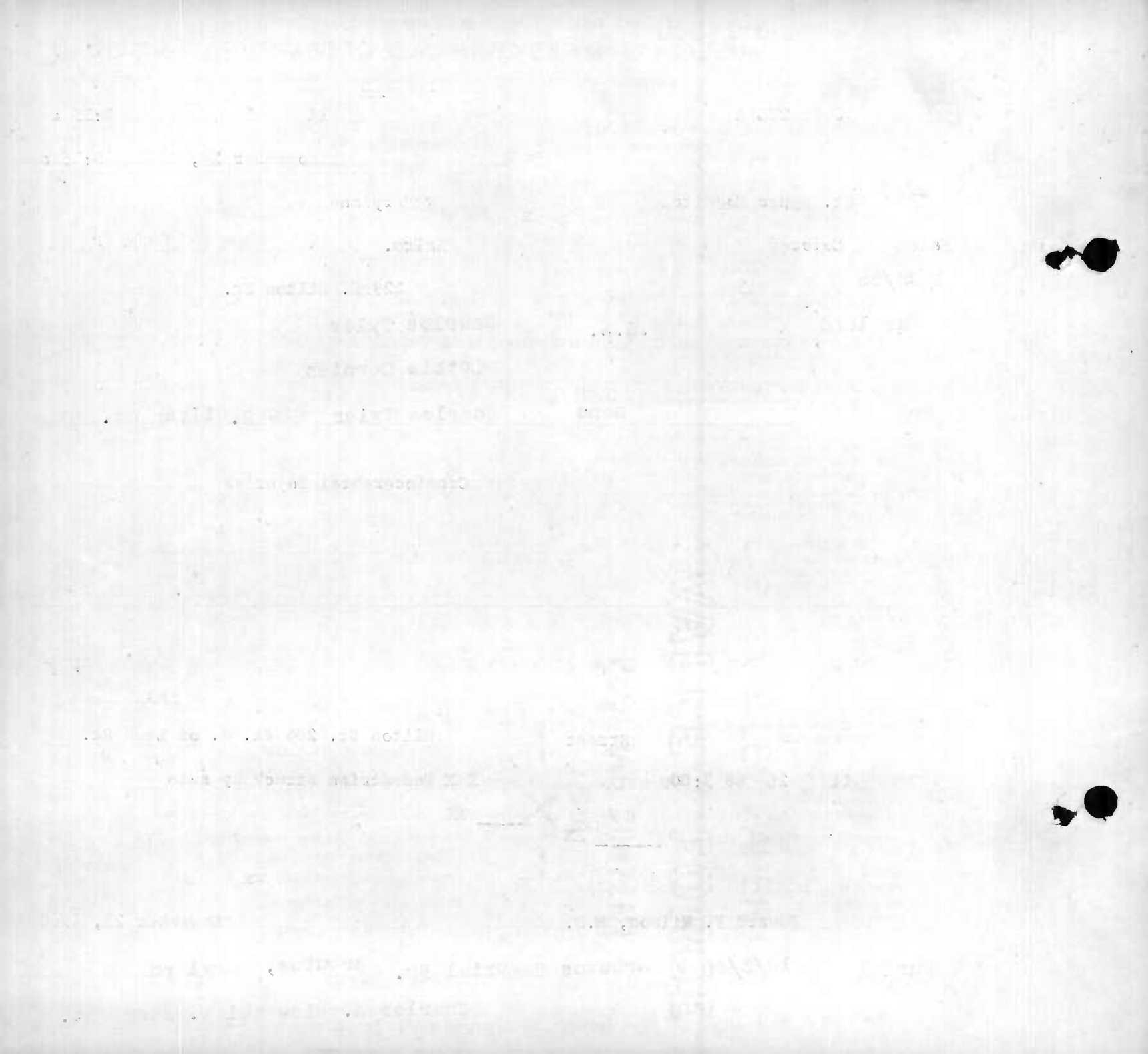
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 29 1968

Charles A. Rice 661 W. Barre St.



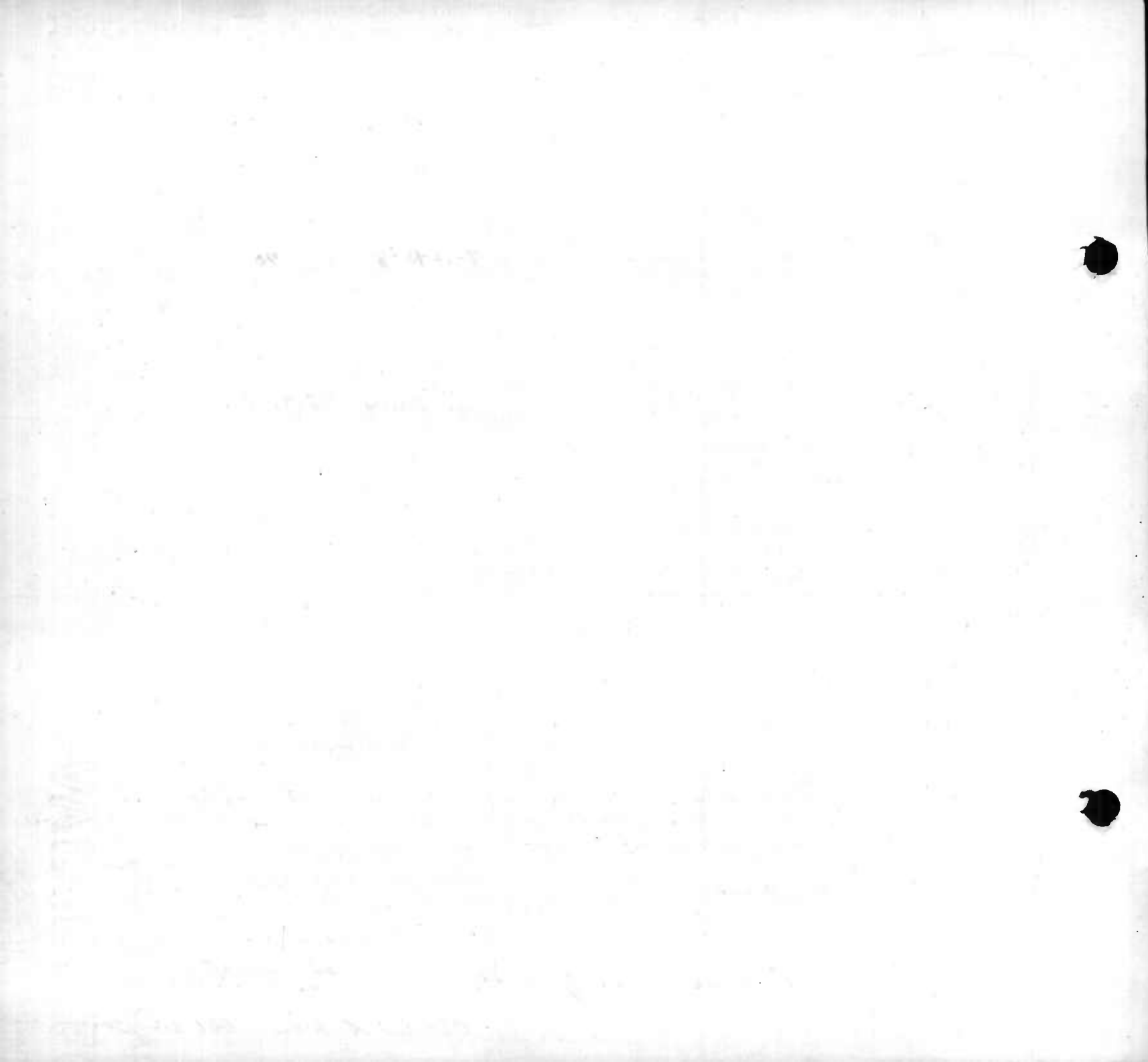
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11941 CERTIFICATE OF DEATH

REG. NO. 68-11941

| | | | | | |
|---|------------------|---|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>FLORY FLOOD</u> | | 2. DATE AND HOUR OF DEATH
<u>11-26-68</u> <u>5 30</u> P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>INSIDE CITY LIMITS?</u> YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>38 UNIVERSITY OF MARYLAND HOSPITAL</u> | | | C. CITY OR TOWN <u>BALTIMORE</u>
E. STREET AND NUMBER <u>812 W. BARRÉ ST.</u> # <u>30</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7-12-1898</u> | 9. AGE (In years last birthday) <u>70</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>S. C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | 13. FATHER'S NAME <u>MILES BELSER</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>MARY</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT <u>Jean Davis</u> ADDRESS <u>812 W. Barré St.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Prot. multiple pulmonary emboli and cerebral.</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Acute fibrillation</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<u>HASCD</u>
(C) <u>Acute renal failure</u> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>443X II</u> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>18 November 19 68</u> to <u>26 November 19 68</u> , that (I) (we) last saw the deceased alive on <u>26 November 19 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Jean M. Jackson, M.D.</u> | | | | 23B. DATE SIGNED <u>26 November 68</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>JEAN M. JACKSON, M.D.</u> | | | | 23D. ADDRESS <u>Green & Rawwood Sts. University of Md. Hospital Baltimore Md.</u> | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-1-68</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Liberty Hill</u> | |
| 24D. LOCATION (City, town, or county) <u>Summerton South Carolina</u> | | 24E. STATE (State) <u>South Carolina</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Charles E. Jackson</u> | | 25C. FUNERAL DIRECTOR <u>Charles E. Jackson</u> ADDRESS <u>661 W. Barré St.</u> | |



68-11942

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11942

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ALICE GRAY

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 27, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1629 Bakebury Court

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 27, 1968

8:25 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

Female

7. RACE

Negro

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

1/3/1900

10. AGE (In years last birthday)

68

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1629 Bakebury Court

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William B. Jones

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Henrietta Buck

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO. A

215-05-2556

18. INFORMANT

ADDRESS

Preston Gray 1629 Bakebury Court

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

432.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 28, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/2/68

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 29 1968

25B. NAME OF REGISTRAR

Robert E. Springate

25C. FUNERAL DIRECTOR

Charles A. Rice

ADDRESS

661 W. Barre St.

WALLER

WALLER

WALLER

WALLER

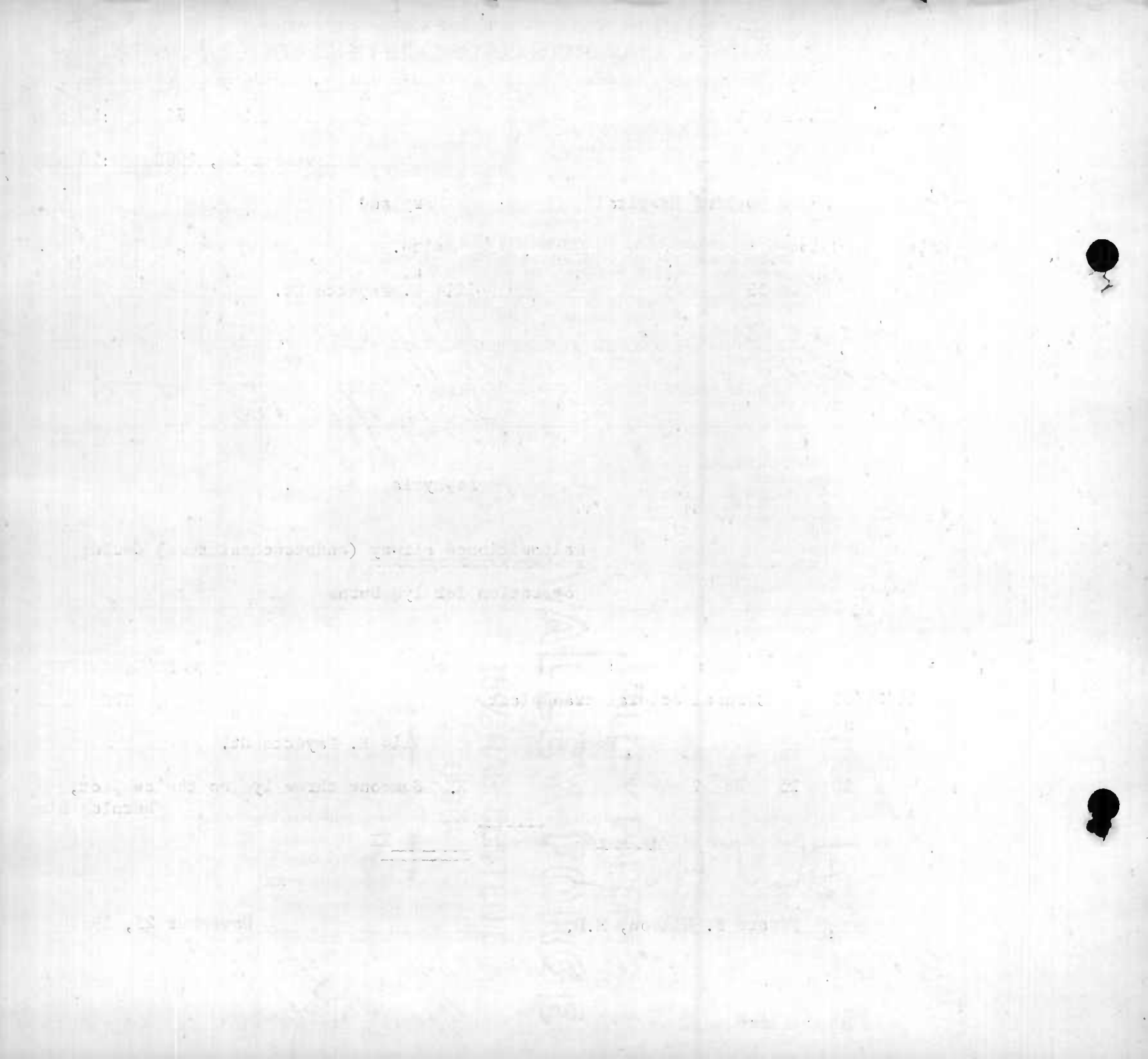
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11943

REG. NO.

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
WILLIAM YOUNG | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> 11 24 68
4:20 p M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
33 Johns Hopkins Hospital | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
November 24, 1968 4:20 p M. | |
| 6. SEX
Male | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | |
| 7. RACE
Colored | | C. CITY OR TOWN
Balto. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH
Feb 15, 1936 | | 10. AGE (In years lost birthday)
33 | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Young | | 14. MOTHER'S MAIDEN NAME
Maile | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT
Susie Jefferson | | ADDRESS | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
E961 X + E930 A | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE Asphyxia
DUE TO, OR AS A CONSEQUENCE OF:
(B) malpositioned airway (endotracheal tube) during
operation for lye burns
(C) operation for lye burns | |
| 20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
E983X II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | |
| 20A. DATE OF OPERATION
11/24/68 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Corneal scleral transplant | |
| 21. AUTOPSY? (Yes or No)
YES | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
1114 E. Fayette St. | | 22D. TIME (Month) (Day) (Year) (Hour)
10 25 68 ? | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Someone threw lye on the subject, | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| ACTUAL SIGNATURE
Edward F. Wilson
EXAMINER'S NAME (Type)
Edward F. Wilson, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE | |
| 24C. NAME OF CEMETERY or CREMATORY
Westport | | 24D. LOCATION (City, town, or county) (State)
Westport | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 29 1968 | | 25B. NAME OF REGISTRAR
Robert E. Jefferson | |
| 25C. FUNERAL DIRECTOR
Frank T. Elicker | | ADDRESS
1129 D. Carbon St | |



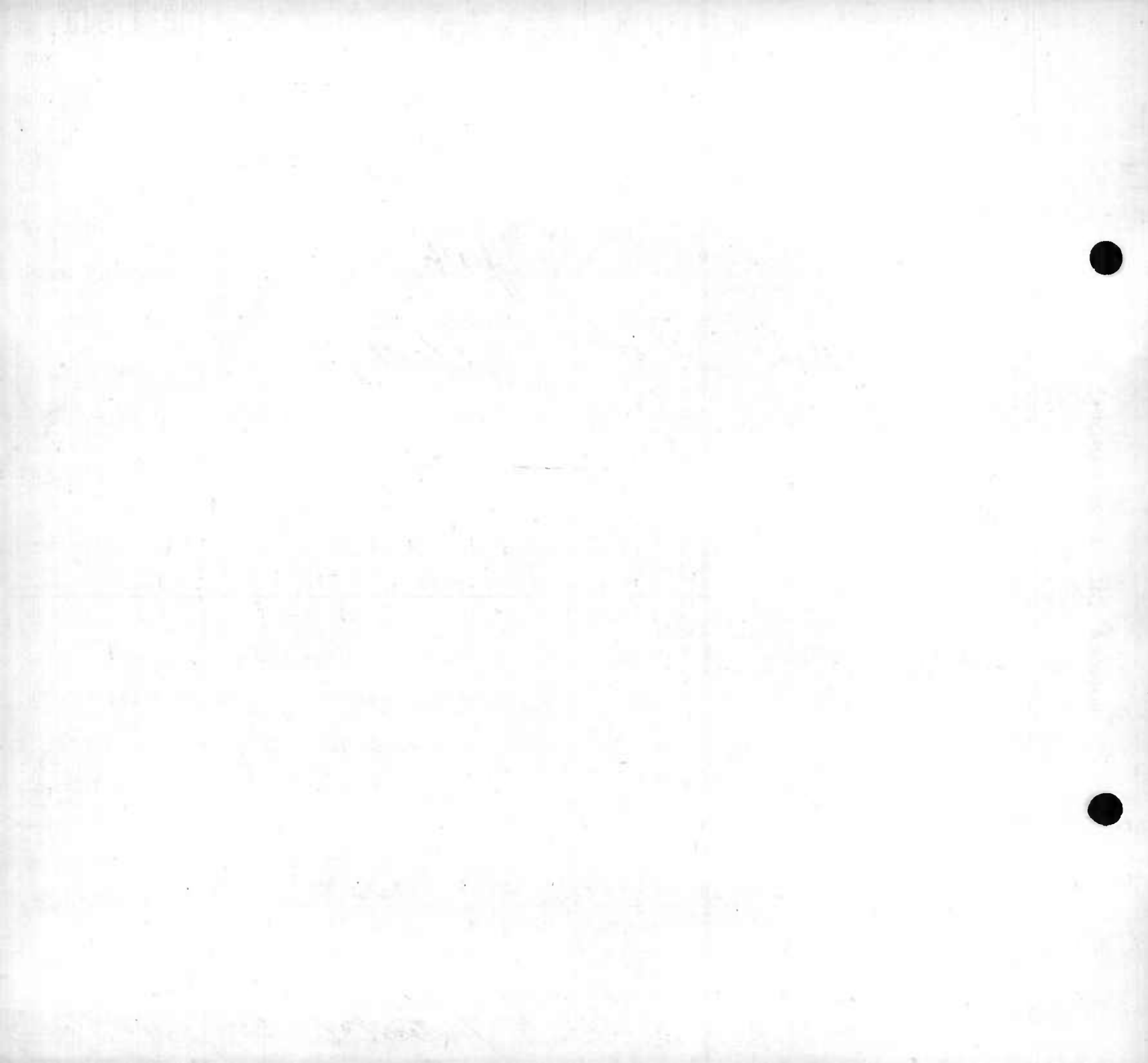
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11944 CERTIFICATE OF DEATH

REG. NO. 68-11944

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>T. B. Lererett</i> | | 2. DATE AND HOUR OF DEATH
<i>November 22 1968</i> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>md.</i> B. COUNTY | | 5. CITY OR TOWN <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>002453 Brentwood Ave.</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <i>Male</i> | | 6. RACE <i>Colored</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <i>Feb 26 1890</i> | | 9. AGE (In years last birthday) <i>78</i> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Georgia</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>Allen Lererett</i> | | 14. MOTHER'S MAIDEN NAME <i>Heathy Hurd</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World War II</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Marshall Lererett</i> ADDRESS <i>2453 Brentwood Ave</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>Cerebral thrombosis and arteriosclerotic heart disease</i> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>332X II</i> | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>arteriosclerosis</i> | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<i>arteriosclerosis</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<i>Diabetes mellitus</i> | | (C) <i>Diabetes mellitus</i> | | <i>3 years -</i> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 20 1967</i> to <i>Nov. 21 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov. 21 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Frank Quinn, MD</i> | | 23B. DATE SIGNED <i>11-25-68</i> | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS | | 23E. DEGREE | | 23F. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| 24G. FUNERAL DIRECTOR ADDRESS | | 24H. DATE | | 24I. NAME OF REGISTRAR | |
| 24J. FUNERAL DIRECTOR ADDRESS | | 24K. DATE | | 24L. NAME OF REGISTRAR | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11945

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JEANETTE HARWELL

2. DATE
OF
DEATHKnown ☐ Month Day Year Hour
Estimated ☐ November 20, 1968 1:52 P. M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

HOPKINS HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD Month Day Year Hour
November 20, 1968 1:52 P. M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY6. SEX
Female7. RACE
Negro8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐C. CITY OR TOWN
BaltimoreD. INSIDE CITY LIMITS?
YES ☐ NO ☐

9. DATE OF BIRTH

April 15, 1901

10. AGE (In years lost birthday) 67
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.E. STREET AND NUMBER
1009 Warden Street

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mamie W. Stey Yourborough

19. E990 X + 303.9

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

Asphyxia

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Smoke and Soot Inhalation

DUE TO, OR AS A CONSEQUENCE OF:

(C)

E916.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Acute Ethylism

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
Home22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1009 Warden Street - 1st floor front

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) November 20, 1968 1:48 p. m.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Asphyxiated

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 21, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Nov 25 1968

24C. NAME of CEMETERY or CREMATORY

Mt Calvary Cem

24D. LOCATION (City, town, or county) (State)

A.A. County Md

25A. DATE REC'D BY HEALTH DEPT.

NOV 29 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Milton E. Elchen 1129 N. Carey

ADDRESS

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>68-11946</u> |
|---|--|---|--|--|
| 68-11946 | | | | 68-11946 |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Rosa L. Berry</u> | | 2. DATE AND HOUR OF DEATH
<u>November 22, 1968</u> M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>md</u> B. COUNTY <u>8</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>1510 E. Chase St</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>Female</u> | | 6. RACE <u>Caucasian</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <u>Apr 22, 1906</u> 9. AGE (In years last birthday) <u>62</u> |
| 13. FATHER'S NAME
<u>John Ford</u> | | 14. MOTHER'S MAIDEN NAME
<u>Virginia</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Prince Edw. Cty. Va.</u> 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Gladys Berry</u> ADDRESS <u>1510 E. Chase St</u> |
| 18. <u>174X</u> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>Carcinoma - Uterus 2-3 yrs</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>174X II</u> | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-1-1968</u> to <u>11-22-1968</u> , that (I) (we) last saw the deceased alive on <u>11-21-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Wm. L. Berry M.D.</u> | | | | 23B. DATE SIGNED
<u>11-26-68</u> |
| 23C. PHYSICIAN'S NAME (Type)
<u>W.M. L. BERRY M.D.</u> | | 23D. ADDRESS
<u>1237 N. Caroline</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>Nov 26/68</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Beth Natl Cem</u> |
| 24D. LOCATION (City, town, or county) (State)
<u>5501 Frederick Rd</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>NOV 29 1968</u> | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR
<u>Zora L. Edickson</u> ADDRESS <u>1129 N. Caroline</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11947

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11947

| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Warrington, Richard | | 2. DATE AND HOUR OF DEATH
10-24-68 6:45 a. m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | C. CITY OR TOWN Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
39 Provident Hospital
1514 Division Street
Baltimore, Maryland | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Male | | 6. RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 8-11-27 | | 9. AGE (In years last birthday) 41 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Social Security | | 10B. KIND OF BUSINESS OR INDUSTRY
Government | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Richard Warrington | | 14. MOTHER'S MAIDEN NAME
Leslie Hard | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes Med. Major | | 16. SOCIAL SECURITY NO.
216-20-8406 | | 17. INFORMANT Mrs. Jessie Warrington ADDRESS 2030 W. Lexington Street (Wife) | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF:
with Cardiogenic Shock
(B) Acute Dermatitis
DUE TO, OR AS A CONSEQUENCE OF:
(C) HCD | | | |
| 19. DATE OF OPERATION 420.1 II | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 11-20-68 to 11-24-68 that (I) (we) last saw the deceased alive on 11-24-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
by G. Tengco | | 23B. DATE SIGNED 11-25-68 | | 23C. PHYSICIAN'S NAME (Type) Dr. A. Paleyfox / G. Tengco | |
| 23D. ADDRESS Provident Hospital
1514 Division Street - Baltimore, Maryland | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Nov 27 1968 | |
| 24C. NAME OF CEMETERY OR CREMATORY Bald. Natl. Cem. | | 24D. LOCATION (City, town, or county) (State) 5501 Fredrick Ave | | 25A. DATE REC'D BY HEALTH DEPT. NOV 29 1968 | |
| 25B. NAME OF REGISTRAR Robert E. Fairbanks | | 25C. FUNERAL DIRECTOR Joseph G. Clickner | | 25D. ADDRESS 1129 N. Calvert | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 68-11948 | | 08-11948 | |
|--|-------------------------|---|-----------------------------------|---|--|---|----------------------------------|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) Bernard Ralph | | | | 2. DATE AND HOUR OF DEATH
11-22-68 10:32 a.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Provident Hospital, Inc.
Baltimore, Maryland 21217 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1308 N. Caroline St. | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-5-99 | 9. AGE (in years last birthday)
69 | 10. If Under 1 Yr. Months: Days: Hours: Min. | | 11. If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
James Ralph | | | |
| 14. MOTHER'S MAIDEN NAME
Mary Jackson | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
Mrs. Elizabeth Ralph- wife | | | |
| 18. 402X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Cardiac arrest following atrial fibrillation
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Hypertensive heart disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
17 days
3 yrs | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | 20. AUTOPSY? (Yes or No)
No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from November 14, 1968 to November 22, 1968 , that (I) (we) last saw the deceased alive on November 22, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
James D. Carr | | | | 23B. DATE SIGNED
11-22-68 | | | |
| 23C. PHYSICIAN'S NAME (Type)
James D. Carr, M.D. | | | | 23D. ADDRESS
1427 Madison Ave 21217 Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
11-26-68 | | | |
| 24C. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Bath | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md | | | |
| 25A. REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR
Rayner Sanders | | | |
| 25C. FUNERAL DIRECTOR
217 E. Preston St | | | | 25D. ADDRESS | | | |



68-11949

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11949

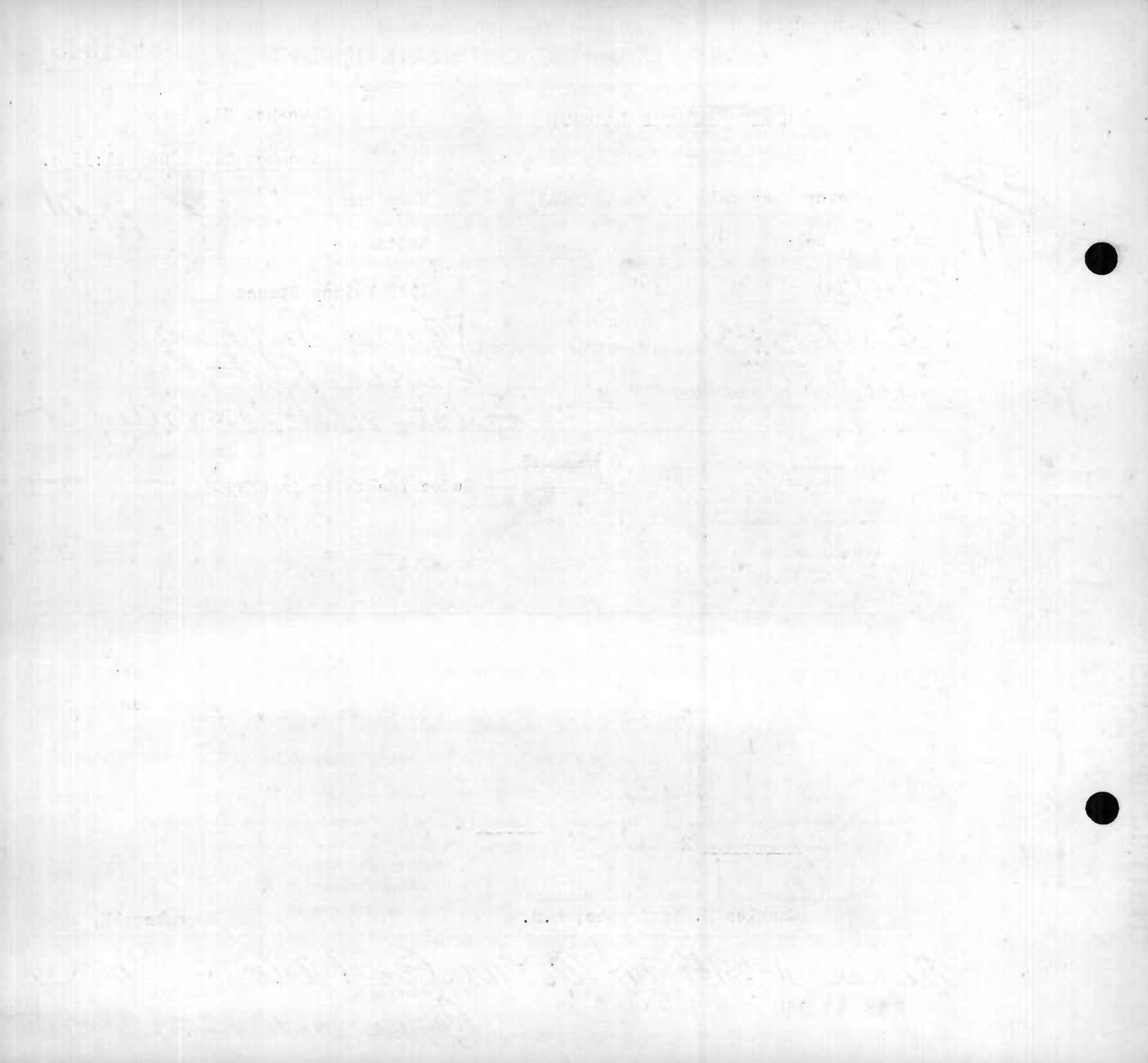
BIRTH NO. 68 17790

REG. NO.

| | | | | |
|---|-------------------------|--|--|---|
| 1. NAME OF DECEASED
(Type or Print)
ELDRID IKNATHIUS TUBMAN | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year
November 21, 1968 | | Hour
M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
Mercy Hospital (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
November 21, 1968 | | Hour
11:55 A.M. |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY | | | | |
| 6. SEX
Male | 7. RACE
Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore |
| 9. DATE OF BIRTH
9/10/68 | | 10. AGE (In years lost birthday)
3 | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country)
Baltimore | | 12. CITIZEN OF WHAT COUNTRY? | | E. STREET AND NUMBER
1219 Valley Street |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. FATHER'S NAME
James Tubman |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Eileen Kent |
| | | | | ADDRESS
Eileen Kent 1219 Valley St |

| | | | |
|--|--|--|--|
| 19. CAUSE OF DEATH
795X1 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Sudden death in infancy
DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION
795.2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 21. AUTOPSY? (Yes or No)
Yes | |
| ACTUAL SIGNATURE
Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Charles S. Springate, M.D. | | DATE SIGNED
November 22, 1968 | |

| | | | |
|---|--|--|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
11-25/68 | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem. | 24D. LOCATION (City, town, or county) (State)
A.A. Co Md |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 23 1968 | 25B. NAME OF REGISTRAR
Robert E. Sanders | 25C. FUNERAL DIRECTOR
Rayner Sanders | ADDRESS
217 E. Preston St |



FUNERAL DIRECTOR: IMPORTANT
DR. WILSON OF THE MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 5-152 68-11950 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 68-11950 | |
|--|----------------------|---|---------------------------------|---|--|---|------------------------------|
| 1. NAME OF DECEASED (Type or Print) <u>Marian Spence</u> | | | | 2. DATE AND HOUR OF DEATH <u>11/24/1968</u> <u>2:08 A</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <u>Md.</u> | | B. COUNTY <u>Balto City</u> | |
| 33 Johns Hopkins Hospital | | | | C. CITY OR TOWN <u>Balt.</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>28 N. Burdon St</u> | | <u>908 N. Durham St</u> | |
| 5. SEX <u>Female</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/23/29</u> | 9. AGE (In years last birthday) <u>39</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Clifton Davis</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah McMillan</u> <u>327-8333</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>MB Marchildon, MD</u> <u>JHA Dept Surg.</u> | |
| 18. <u>577.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. IMMEDIATE CAUSE <u>Cardiac arrest</u> | | | | <u>3 min.</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| 19B. ANTECEDENT CAUSES | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| (B) <u>Gram Negative Septicemia</u> | | | | <u>3 days</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| (C) <u>Pancreatitis; ? Pyelonephritis</u> | | | | <u>4 weeks</u> | | | |
| 19C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) <u>Cirrhosis</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>3/11/21/68</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Septicemia - ? Pancreatic abscess</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Not Performed yet</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> 19 <u>68</u> to <u>11/24</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/24</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>MB Marchildon MD</u> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>11/24/68</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Michael B. Marchildon M.D.</u> | | | | 23D. ADDRESS <u>J.H.H. Dept. Surgery Balto Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>11-27-68</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cem Balto</u> | | 24D. LOCATION (City, town, or county) (State) <u>Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT <u>NOV 29 1968</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Rayner Sanders</u> | | ADDRESS <u>217 E. Preston St</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

68-11951

| | | | | | |
|--|-------------------------|--|------------------------------------|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Clara Edmonds | | 2. DATE AND HOUR OF DEATH
NOV 22, 1968 2:45 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital
ADDRESS OR LOCATION 4940 Eastern Ave
Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2709 E. Federal St. | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-21-24 | | 9. AGE (In years last birthday)
44 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY
At home | | 11. BIRTHPLACE (State or foreign country)
North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Simon Alex Brown | | | |
| 14. MOTHER'S MAIDEN NAME
Clara Brown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
BCH Records 4940 Eastern Ave Baltimore, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
MYOCARDIAL INFARCTION | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 MIN | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
DIABETES MELLITUS, HYPERTENSION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
572.1 II | | | | | |
| 19A. DATE OF OPERATION
11-21-68 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
DUVERTICULITIS WITH PERF. | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-21-68 to 11-22-68 , that (I) (we) last saw the deceased alive on 11-22-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
W. E. Powers, Jr. M.D. | | | | 23B. DATE SIGNED
11-22-68 | |
| 23C. PHYSICIAN'S NAME (Type)
W. E. POWERS, JR. M.D. | | | | 23D. ADDRESS
4940 Eastern Ave Baltimore, Maryland #21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
11-26-68 | | 24C. NAME of CEMETERY or CREMATORY
Mt. Calvary Cemetery | |
| 24D. LOCATION
Anne Arundel Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
NOV 29 1968 | | | |
| 25B. NAME OF REGISTRAR
Charles E. [illegible] | | 25C. FUNERAL DIRECTOR
Randolph J. Collick 2431 E. Oliver St. | | | |

At home

Classroom

1-25-63 Mr. C. J. [unclear] [unclear]
[unclear] [unclear] [unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11952 CERTIFICATE OF DEATH

REG. NO. 68-11952

| | | | | | |
|---|---------|---|------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Clara Whitlock | | Nov. 21, 1968 7 ²⁵ A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
1105 E. Fayette Street | | | | A. STATE Maryland
B. COUNTY Baltimore | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER | | | | 1708 E. Lanvale St. | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| F | N | | 9-11-1881 | 87 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Domestic | | At home | | Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| George Coleman | | Lucinda Clark | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 116-26-9210A | | Lee Cousins 1708 E. Lanvale St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | |
| 422.1 II | | | | Conjunctive Heart Failure | |
| ANTECEDENT CAUSES | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | 2 weeks | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | Diabetes Mellitus | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) was attended the deceased from Sept. 3, 1968 to Nov. 21, 1968, that (I) was last saw the deceased alive on Nov. 21, 1968 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| E. Ellsworth Cook | | | | Nov. 21, 1968 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| E. Ellsworth Cook | | | | M.D. 2431 Maryland Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Removal | | 11-23-68 | | Fairview Cemetery Phila. | |
| 25A. DATE RECEIVED BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| NOV 23 1968 | | R. J. Collick | | 2431 E. Oliver St. | |

George C. Brown
Lucinda Clark

11-25-88
George C. Brown
Lucinda Clark

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
REG. NO. 68-11953 | | | |
|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) MARY JEFFERS | |
| 2. DATE AND HOUR OF DEATH
11/21/68 | | 11 45 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
33 THE JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE CITY
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 15-04 | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-3-02 |
| 9. AGE (In years last birthday)
66 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY
At Home | |
| 11. BIRTHPLACE (State or foreign country)
Roxboro, N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
GREENIE DIXON | | 14. MOTHER'S MAIDEN NAME
WINNIE JOHNSON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Clyde Jeffers 2621 Telford Rd. | | ADDRESS | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ASPIRATION PNEUMONIA | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
36 hrs | |
| 19. 420.1 II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
POSSIBLE MI | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN IDENTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 19 1968 to Nov 21 1968 , that (I) (we) last saw the deceased alive on 11/21 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Michael D. Lutz, M.D. | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
MICHAEL D. LUTZ, M.D. | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
11-26-68 | 24C. NAME of CEMETERY or CREMATORY
Arbatus Mem. PK. | 24D. LOCATION (City, town, or county) (State)
Arbatus, Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 29 1968 | 25B. NAME OF REGISTRAR
Robert E. Johnson | 25C. FUNERAL DIRECTOR
Randolph J. Collick | ADDRESS
2431 E. Chiswick St. |

20302. Bentalan H.

30 45

379 308.221

Michael D. Lee

WICHITA FALLS, TEXAS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11954

BIRTH NO.

REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) DIANE M. KELLY | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> 11 24 68 12:15 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Church Home and Hospital D.O.A. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
November 24, 1968 12:15 a | |
| 6. SEX
Female | | 7. RACE
Colored | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
6-10-54 | | 10. AGE (In years lost birthday) 15 14 | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Robert Kelly | | 14. MOTHER'S MAIDEN NAME
Eleanor Decatur | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 16. KIND OF BUSINESS OR INDUSTRY | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 18. SOCIAL SECURITY NO.
NONE | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Epilepsy
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
345.9
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
353.3 | | 20. DATE OF OPERATION | |
| 21. AUTOPSY? (Yes or No)
YES | | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 23. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 24. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 25. TIME OF INJURY (APPROX.) | | 26. HOW DID INJURY OCCUR? | |
| 27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 28. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| 29. ACTUAL SIGNATURE OF EXAMINER'S NAME (Type)
Edward F. Wilson, M.D. | | 30. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 31. DATE REC'D BY HEALTH DEPT.
NOV 29 1968 | | 32. NAME OF REGISTRAR
Robert E. Jackson | |
| 33. DATE OF BURIAL CREMATION, REMOVAL (Specify)
Burial | | 34. DATE
11-30-68 | |
| 35. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cemetery | | 36. LOCATION (City, town, or county) (State)
Anne Arundel Co., Md. | |
| 37. FUNERAL DIRECTOR
Randolph J. Collick | | 38. ADDRESS
2431 E. Oliver St. | |

Mr. J. H. [illegible]

2-10-24

Baltimore, Md.

My

no

name

Robert Kelly

Eleanor Doonan

Eleanor Kelly Doonan

WALTER W. [illegible]

ROYAL [illegible]

Bureau 11-30-24 [illegible]

Philip [illegible]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11955

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CECELIA MATTHEWS

2. DATE OF DEATH

Known ☐ Estimated ☒Month Day Year
November 24, 1968Hour Minute
12:55 P.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (If NOT in HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
HOSPITAL OR INSTITUTION

930 S. Sharp Street

3. DATE

Month Day Year
November 24, 1968Hour Minute
12:55 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

9. DATE OF BIRTH

2/11/1914

10. AGE (In years last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

930 S. Sharp Street

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

JAMES H. MATTHEWS

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

MARY E. SAVOY

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

BERTHA M. EVAN 617 N. Payson

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Subdural Hemorrhage

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Fatty Liver

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

20. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

22A. DATE OF OPERATION 22B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

930 S. Sharp Street

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Nov. ?? 68 Unk. m.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Found lying on floor

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 25, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-2-68

24C. NAME of CEMETERY or CREMATORY

Mt Calvary

24D. LOCATION (City, town, or county) (State)

A.A.CO., Md

25A. DATE REC'D BY HEALTH DEPT.

DEC 2 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Isaiah L. Brown and Son
108 W. Montgomery Street

ADDRESS

MARYLAND

JAMES H. MATTHEWS
MARY E. SAVOY

BERNARD M. BOWEN & SONS

BRIDGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11956 CERTIFICATE OF DEATH

REG. NO. 68-11956

| | | | | | |
|--|--|---|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Gertrude Jaworski</i> | | 2. DATE AND HOUR OF DEATH
<i>11/28/68 1:00 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>42 Sinai Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE <i>MD</i> B. COUNTY <i>27-19</i> | |
| 5. SEX
<i>Fem</i> | | 6. RACE
<i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
<i>10-30-1930</i> | | 9. AGE (In years lost birthday) <i>38</i> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Nurse</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<i>Lublin Poland</i> | | | | 12. CITIZEN OF WHAT COUNTRY?
<i>Poland</i> | |
| 13. FATHER'S NAME
<i>VALENTI</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>PAULINE SZAFLIK</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Jerzy Jaworski 4044 W Rogers</i> | |
| 18. <i>430.9 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

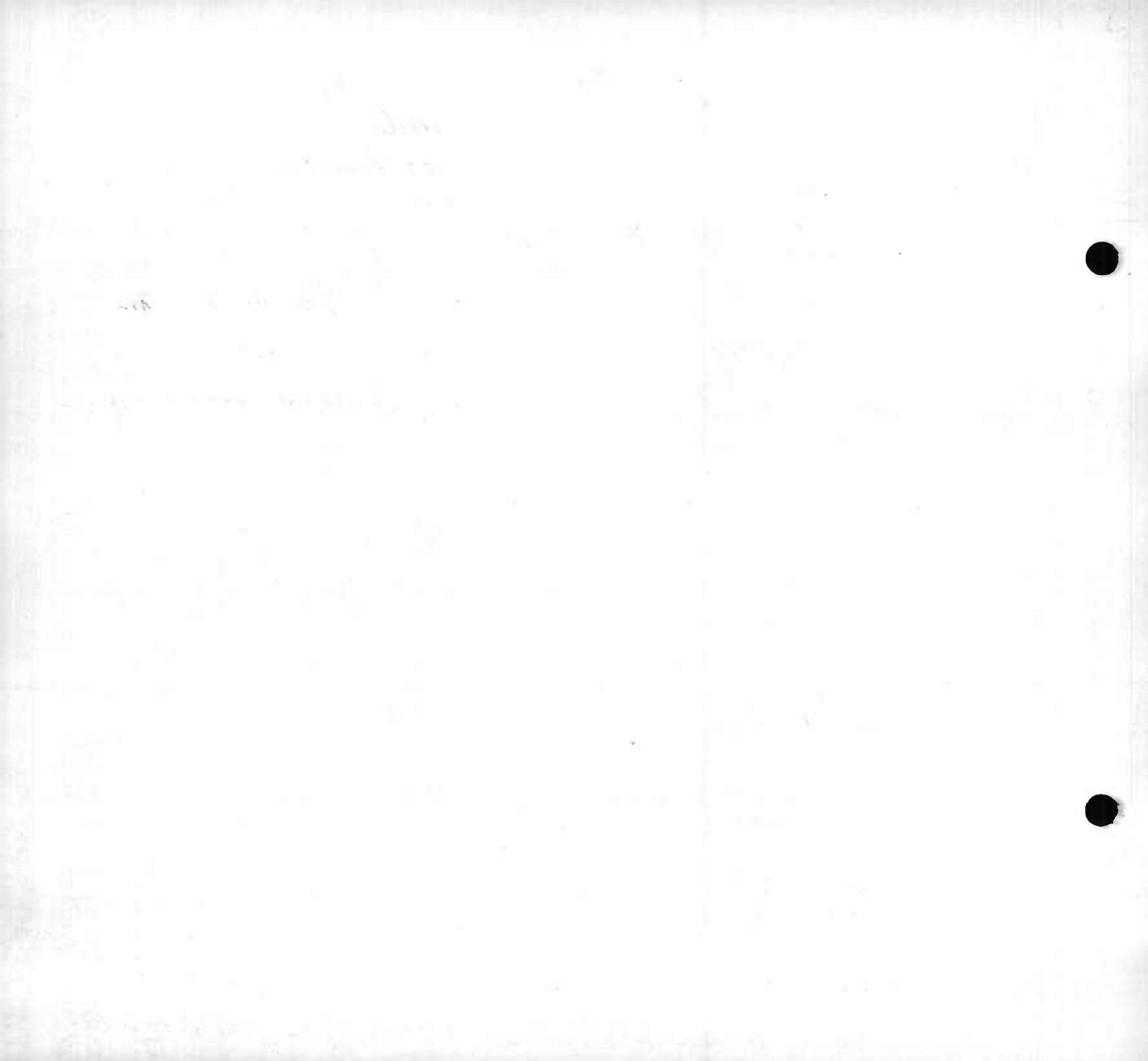
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>330x II</i> | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>Subarachnoid Hemorrhage</i>

(B) <i>? Ruptured Berry aneurysm</i>
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i>

<i>2 days</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/26 19 68</i> to <i>11/28 19 68</i> , that (I) (we) last saw the deceased alive on <i>11/28 19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Howard P. Friedman M.D.</i> | | | | 23B. DATE SIGNED
<i>11/28/68</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>HOWARD P. FRIEDMAN M.D.</i> | | | | 23D. ADDRESS
<i>Sinai Hospital Baltimore, Md</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>12/2/68</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>St Stanislaus Cem</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Bkto Md</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 2 1968</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. [Signature]</i> | | 25C. FUNERAL DIRECTOR
<i>Thomas J. Kerry Inc 1600 Bellair</i> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 68-11957 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 68-11957 | |
|--|------------------|---|------------------------------------|---|----------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print) | | MAGDALENE SPAMER | | 2. DATE AND HOUR OF DEATH
Nov. 27, 1968. | | 1 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 3004 Frisby Street | | | | A. STATE Md. | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
3004 Frisby Street | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 15, 1886. | 9. AGE (In years lost birthday)
82 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Charles Zoll | | | | 14. MOTHER'S MAIDEN NAME
Anne Winkler | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Helen Pierpont | | ADDRESS
(Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
1977-8-1
Hypoproteinemia, anemia.
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
156.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH
Hypoproteinemia, anemia.
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Liver disease.
(B) DUE TO, OR AS A CONSEQUENCE OF:
?? carcinoma.
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mo
1 yr.
7 | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the undersigned) attended the deceased from July 16, 1968 to Nov 26, 1968; that (I) last saw the deceased alive on Nov 21, 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death. | | | | | | | |
| 23A. SIGNATURE
N.R. Freeman Jr. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
11/27/68 | |
| 23C. PHYSICIAN'S NAME (Type)
N.R. FREEMAN JR. | | | | 23D. ADDRESS
11W. 29th St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/30/68. | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Jansky | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. | | 25D. ADDRESS
21214 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11958

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11958

| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print)
Knachel, Elizabeth | | 2. DATE AND HOUR OF DEATH
November 27, 1968 1:44 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md.
B. COUNTY Baltimore | | 5. CITY OR TOWN
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Harford Gardens Convalescent Home
4700 Harford Road | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
Female | | 6. RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 1879-12-29
9. AGE (In years last birthday) 88 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Ernest Voelker | |
| 14. MOTHER'S MAIDEN NAME
Collenberg, Matilda | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-48-4664 T | |
| 17. INFORMANT
Mrs. Matilda E. Meyer | | ADDRESS
(Same) | | 18. CAUSE OF DEATH
Arterio Sclerosis Vasculi Cerebri
Angiomatic Heart Failure
Chronic Chylitis | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
450.0 II | | 20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 21. DATE OF OPERATION | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 23. AUTOPSY? (Yes or No) | | 24. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 25. DATE OF OPERATION | |
| 26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 29. TIME OF INJURY (APPROX.) | | 30. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 31. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March - 25 - 1959 to Nov - 21 - 1968 , that (I) was last saw the deceased alive on Nov - 22 - 1968 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did not view the body after death. | | 23A. SIGNATURE
Dr. William G. Geyer | | 23B. DATE SIGNED
Nov - 27 - 68 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. William G. Geyer | | 23D. ADDRESS
156 N. MILTON AVE. | | 24. NAME OF CEMETERY or CREMATORY
Oak Lawn Cemetery | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/30/68. | | 24C. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | |

1911

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11959

BIRTH NO.

REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
CHARLES KOHLERMAN | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> November 28, 1968 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
Baltimore City Hospital (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
November 28, 1968 2:45 A.M. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
Feb. 3, 1927. | | 10. AGE (In years last birthday)
41 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 14B. KIND OF BUSINESS OR INDUSTRY
Social Security | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes W W2 | | 18. INFORMANT
Mrs. Anna Kohlerman | |
| 15. MOTHER'S MAIDEN NAME
Theresa A. Unkelbach | | ADDRESS
(Same) | |
| 19. E 812.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Multiple crushing injuries of trunk | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
street | |
| 22D. TIME OF INJURY (APPROX.)
11-28-68 2:10 A.M. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Boston Street and Bethlehem Street | | 22F. HOW DID INJURY OCCUR?
Passenger in auto-auto collision | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 21. AUTOPSY? (Yes or No)
Yes | |
| ACTUAL SIGNATURE
Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/2/68. | |
| 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 4 1968 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | |

X

Feb. 3, 1967

Memphis

Social Security

Clark

Los Angeles

Mrs. Anna Kellerman

(Sons)

WALTER

FOOT

Mr. Thomas J. Kellerman

12/2/67

trial

Edward J. Kellerman, Jr., wife, et al.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11960

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EMMA M. KRUG

2. DATE AND HOUR OF DEATH

NOV. 27, 1968 10:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

THE UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

727 HASTWOOD DRIVE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

NOV. 5, 1898

9. AGE (In years
last birthday)

70

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BABY SITTER

10B. KIND OF BUSINESS OR INDUSTRY

Ret. L. Grief & Co.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ENGELHARDT

KRUG

14. MOTHER'S MAIDEN NAME

ANNE LEDERTHOSE

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-01-3271A

17. INFORMANT

ADDRESS

CHARIE Miss Mathilda Krug. (Same)

18. 295.31

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

SEVERE DEHYDRATION

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CACHEXIA

(B)

DUE TO, OR AS A CONSEQUENCE OF:

PARANOID SCHIZOPHRENIA

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

17 DAYS

2 MOS.

MEDICAL CERTIFICATION

300.3 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At ☐
Work

Not While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from NOV. 26 1968 to NOV. 27 1968

that (1) last saw the deceased alive on NOV. 27 1968 and that in (my) opinion death occurred on the date

and hour and from the causes stated above. (1) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

HONG TI CHUA, MD

DEGREE

Attending ☐
Phys.

Med. ☐
Director

Staff ☒
Phys.

23B. DATE SIGNED

11-27-68

23D. ADDRESS

The Union Memorial Hosp.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/30/68

24C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

24D. LOCATION

Baltimore, M Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 2 1968

25B. NAME OF REGISTRAR

Robert E. Jarboe

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. M d.

ADDRESS

THE NEW YORK HOSPITAL

FEMALE WHITE

BABY SISTER

ENGELHARDT KNOX

127 HAWKINS ST
NEW YORK

Nov 2, 1898

MARYLAND

WINE CEMENT

GRAND

SEVERE DEHYDRATION

CACHEMIA

PARANOID SCHIZOPHRENIA

Wm. J. Schuler and
Hans T. Schuler, MD

Nov 27

Nov 28

Nov 28

Nov 27

11-27-98

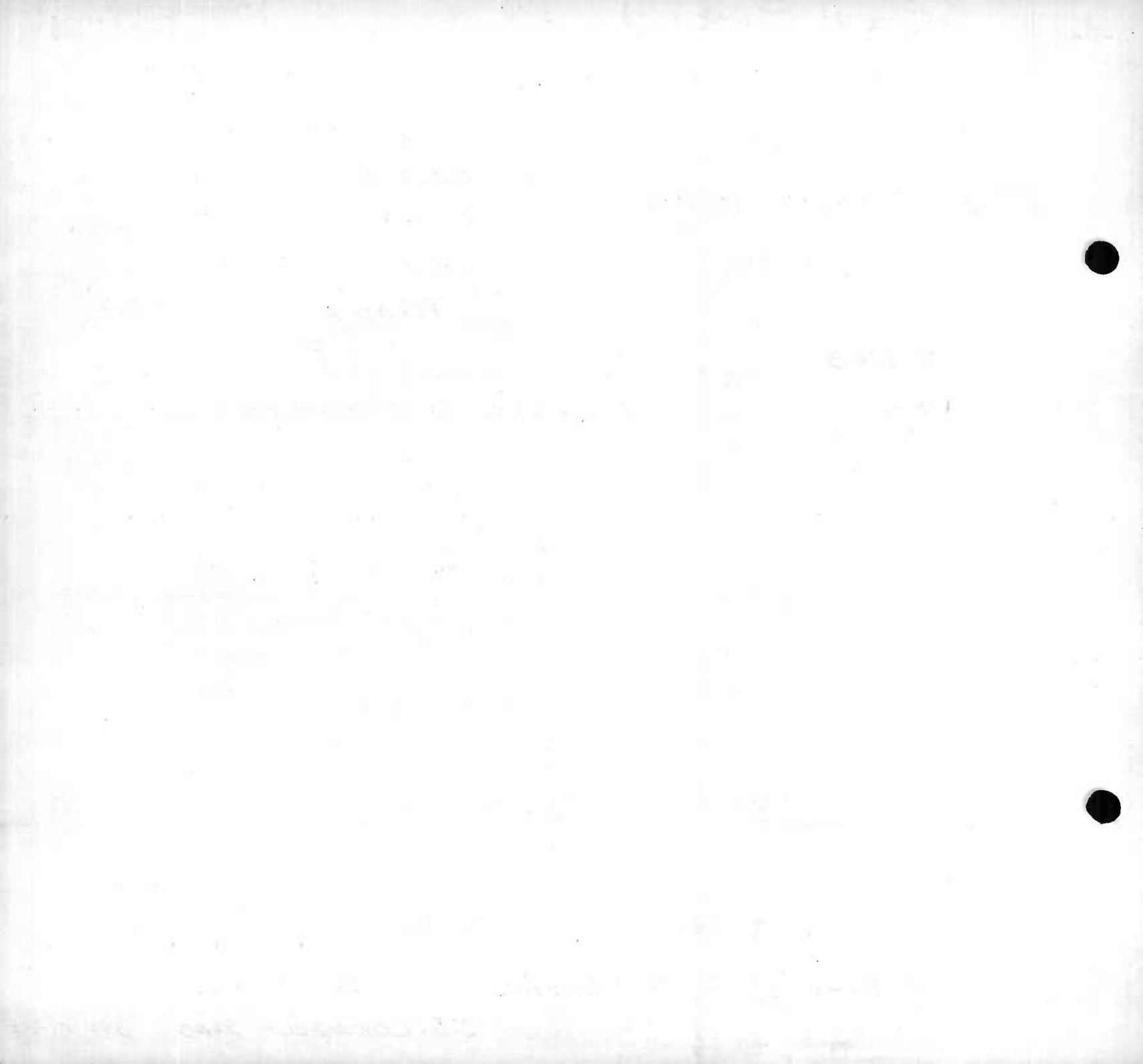
The Journal of the American Medical Association

43-31-15
djs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 0-232 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 68-11961 | | | | | |
|--|--|---------|--|--|--|------------------|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | |
| JOSEPH JAGODZINSKI | | | | NOVEMBER 27, 1968 10 ¹⁰ A.M. | | | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | | | | | | | |
| 4940 EASTERN AVENUE
BALTIMORE, MARYLAND | | | | MARYLAND BALTIMORE | | | | | | | | | |
| 31 BALTIMORE CITY HOSPITALS | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | | | | | | | | | |
| | | | | ESSEX YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| E. STREET AND NUMBER | | | | | | | | | | | | | |
| 315 NICHOLSON ROAD 21221 | | | | | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | | | |
| MALE | | WHITE | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10-17-84 | | 84 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | | | | | POLAND | | | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | |
| JACOB | | | | ? | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | |
| UNK | | | | 220-11-7093 | | | | BCH: RECORDS 4940 EASTERN AVE. BALTO. MD. | | | | 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | PNEUMONIA | | | | 8 days? | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | ARTERIOSCLEROTIC CARDIO-VASC. DISEASE | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) BENIGN PROSTATIC HYPERTROPHY | | | | | | | | | |
| 422.1 II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (D) INGUINAL HERNIA (HERNIORRAPHY DONE) | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | | | | | YES | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examined) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | | | October 21 19 68 to November 27 19 68 | | | | | | | | | |
| that (I) (we) last saw the deceased alive on | | | | November 27 19 68 | | | | and that in (my) (our) opinion death occurred on the date | | | | | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | | | | | |
| J. Torres | | | | 11-27-68 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | | | | | |
| JOSE TORRES M.D. M.D. | | | | BALTIMORE CITY HOSPITALS | | | | | | | | | |
| | | | | 4940 EASTERN AVE. BALTO. MD. 21224 | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | | 24C. NAME of CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | | | 11/30/68 | | | | ST. STASLAUS | | | | BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR | | | | ADDRESS | |
| DEC 3 1968 | | | | Robert E. Johnson | | | | J.C. CONNELLY SONS | | | | 300 MACE | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11962

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JUNIOR R. ROSIER

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ 11 27 68 6:21a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospital D.O.A.

3. DATE PRONOUNCED DEAD

November 27, 1968 6:31 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

BALTO Co

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

3/26/18

10. AGE (In years last birthday)

50

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

24 Control Ct.

11. BIRTHPLACE (State or foreign country)

W. VA.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

MURRAY ROSIER

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CRANE OPERATOR

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

BOLYARD

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

17. SOCIAL SECURITY NO.

234-32-0915

18. INFORMANT

ELLA ROSIER

ADDRESS

ABOVE

19. 011.9

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Chronic lung disease
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Tuberculosis
DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/27/68

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

11/30/68

24C. NAME of CEMETERY or CREMATORY

HOLLY HILL

24D. LOCATION (City, town, or county)

BALTO, MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 2 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

J.E. CONNELLY SONS

ADDRESS

300 MACE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11963 CERTIFICATE OF DEATH

REG. NO. 68-11963

| | | | | | |
|---|------------------------------|---|------------------------------------|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) William B. TANNER | | 2. DATE AND HOUR OF DEATH
11/26/68 4:20 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
34 BON SECOURS HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN (CRATONSVILLE) BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
8 DUNMORE ROAD (21228) | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
1/22/99 | 9. AGE (In years lost birthday)
69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SALES - RET. | | 10B. KIND OF BUSINESS OR INDUSTRY
ENG. SUPPLIES | | 11. BIRTHPLACE (State or foreign country)
W. VA. | |
| 13. FATHER'S NAME
SHERIDAN TANNER | | 14. MOTHER'S MAIDEN NAME
CORDY MYERS | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)
NO | | 16. SOCIAL SECURITY NO.
202-12-6921 | | 17. INFORMANT
PTS. CHART | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Coronary Thrombosis minute | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
A.S.V.D. | | | |
| | | (B) C.V.A. | | | |
| | | (C) C.V.A. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
420.1 II | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1950 to Nov 25 1968 , that (I) (we) last saw the deceased alive on 11/25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J. C. Pounds | | | | 23B. DATE SIGNED
11/26/68 | |
| 23C. PHYSICIAN'S NAME (Type)
J. C. Pounds | | 23D. ADDRESS
3325 Fredrick Ave Balto, Md 29 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
11-29-68 | 24C. NAME of CEMETERY or CREMATORY
Landon Park Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore Ind. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR
John J. Conway & J. H. Catonville, Inc. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11964 CERTIFICATE OF DEATH

REG. NO. 68-11964

| | | | | | |
|--|--|---|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) THOMAS BOLGER | | 2. DATE AND HOUR OF DEATH
11-25-68 10.50 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
FRANKLIN SQUARE HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED-COOK | | 10B. KIND OF BUSINESS OR INDUSTRY
RESTAURANT | | 8. DATE OF BIRTH 8-24-92 9. AGE (In years last birthday) 76 | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
THOMAS BOLGER | | | 14. MOTHER'S MAIDEN NAME
BRIDGET FLEMING | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES W.W.I | | 16. SOCIAL SECURITY NO.
212-72-0944 | | 17. INFORMANT
UTAI RUANGWIT, M.D. ADDRESS FRANKLIN SQUARE HO. | |
| 18. 4109 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CHF + Pneumonia | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Myocardial infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 hrs. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
420.1 II | | (B) DUE TO, OR AS A CONSEQUENCE OF:
Pneumonia Rt lung. | | | |
| 19A. DATE OF OPERATION
11-28-68 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> - Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-12-68 to 11-25-68 , that (I) (we) last saw the deceased alive on 11-25-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Utai Ruangwit, M.D. | | | | 23B. DATE SIGNED
11-25-68 | |
| 23C. PHYSICIAN'S NAME (Type)
UTAI RUANGWIT, M.D. | | 23D. ADDRESS
FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-28-68 | | 24C. NAME OF CEMETERY or CREMATORY
Cathedral Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Grady-Cornough & H. Catonwill Inf. | | | |

184 + 185

Myocardial infarction

Paroxysmal

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
LOUISE WIDERMANN | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
11 28 68 6:10 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
D.O.A. 1520 Byrd St. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
November 28, 1968 6:10 p.m. | |
| 6. SEX
Female | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Balto. | |
| 9. DATE OF BIRTH
May 6, 1905 | | 10. AGE (In years last birthday)
63 | |
| 11. BIRTHPLACE (State or foreign country)
Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Unknown Germaershausen | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Saleslady | |
| 15. KIND OF BUSINESS OR INDUSTRY
Clothing | | 16. MOTHER'S MAIDEN NAME
Unknown Unknown | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service)
No | | 18. SOCIAL SECURITY NO.
Mr. Linwood A. Young | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
Complicated by Pulmonary emphysema | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION
4/22/68 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Complicated by Pulmonary emphysema | |
| 21. AUTOPSY? (Yes or No)
No | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
11 28 68 | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE
Ronald N. Kornblum
EXAMINER'S NAME (Type)
Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
11/29/68 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12 2 68 | |
| 24C. NAME OF CEMETERY or CREMATORY
Glen Haven | | 24D. LOCATION (City, town, or county) (State)
Glen Burnie, A. A. Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
Mc Cully | | ADDRESS
130 E. Fort Ave | |

Abstracts of the Proceedings of the

Conference of the American Society for the Advancement of Science

ALLEN
PRESS

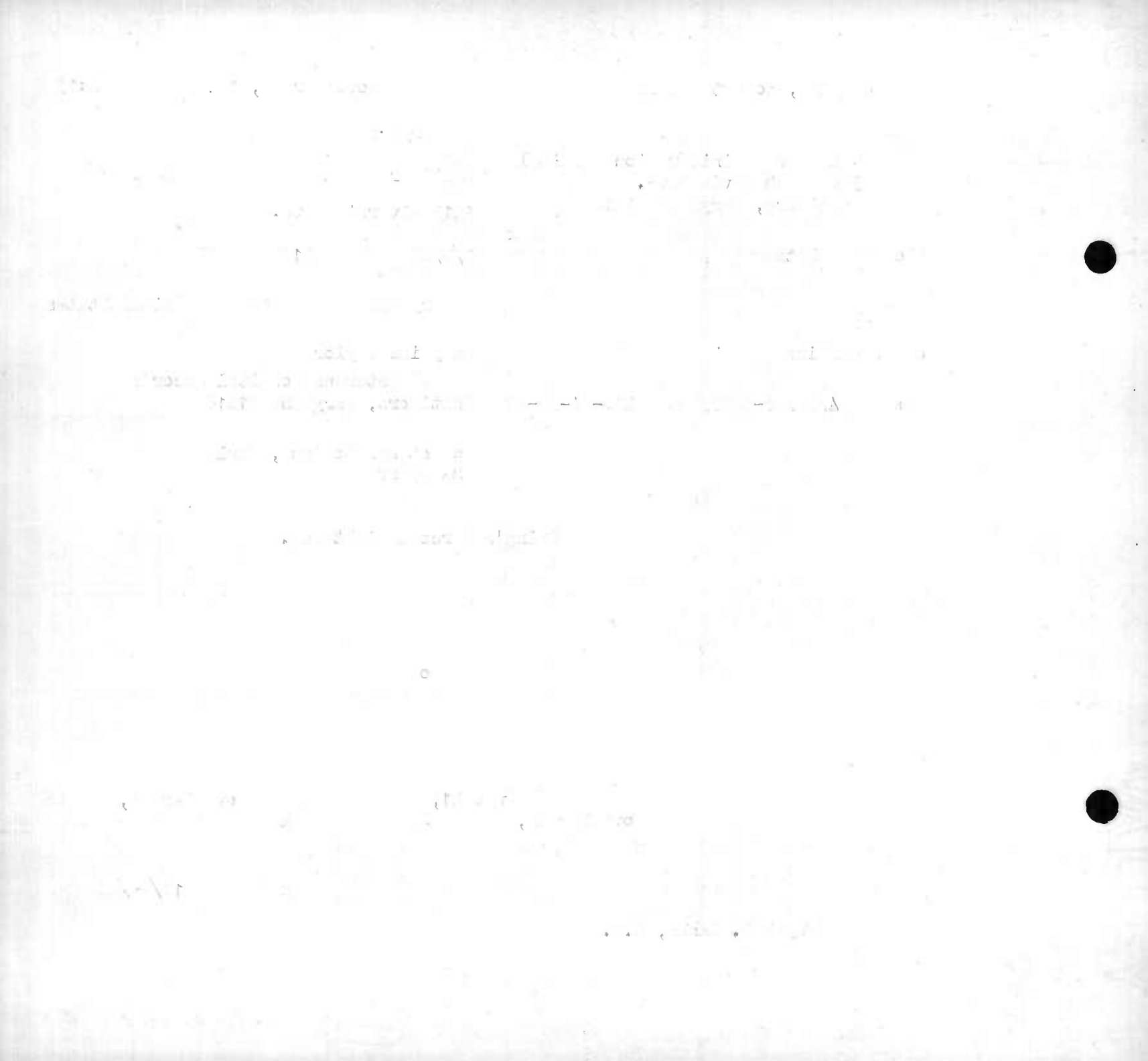
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11966 CERTIFICATE OF DEATH

REG. NO. 68-11966

| | | | | | |
|--|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Jenkins, Robert Edward | | 2. DATE AND HOUR OF DEATH
November 28, 1968 4:15 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY | | 5. SEX
Male | |
| FULL NAME OF HOSPITAL OR INSTITUTION
23 Veterans Administration Hospital
3900 Loch Raven Blvd.
Baltimore, Maryland 21218 | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
1413 Riverside Ave. | | 6. RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
2/9/47 | | 9. AGE (In years lost birthday)
21 | | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
United States | | 13. FATHER'S NAME
James Jenkins | | 14. MOTHER'S MAIDEN NAME
Madylfne Taylor | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 2/30/65-5/15/68 | | 16. SOCIAL SECURITY NO.
218-44-50-89 | | 17. INFORMANT Veterans Hospital Records
Baltimore, Maryland 21218 | |
| 18. 170.87 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Metastases to Lung, Skull and Spine
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Ewing's Sarcoma Right Leg. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) Ewing's Sarcoma Right Leg.
DUE TO, OR AS A CONSEQUENCE OF:
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
1967 II | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that he (this hospital) attended the deceased from June 21, 1968 to November 28, 1968 , that he (we) last saw the deceased alive on November 28, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. he (We) (did) not view the body after death. | | 23A. SIGNATURE
Pfayek G. YASSA, M.D.
DEGREE | |
| 23B. DATE SIGNED
11/28/68 | | 23C. PHYSICIAN'S NAME (Type)
Pfayek G. Yassa, M.D.
DEGREE | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | 24B. DATE
11/28/68 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | |
| 25C. FUNERAL DIRECTOR
McCall - 130 E. Fort St | | 25D. ADDRESS | | 25E. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

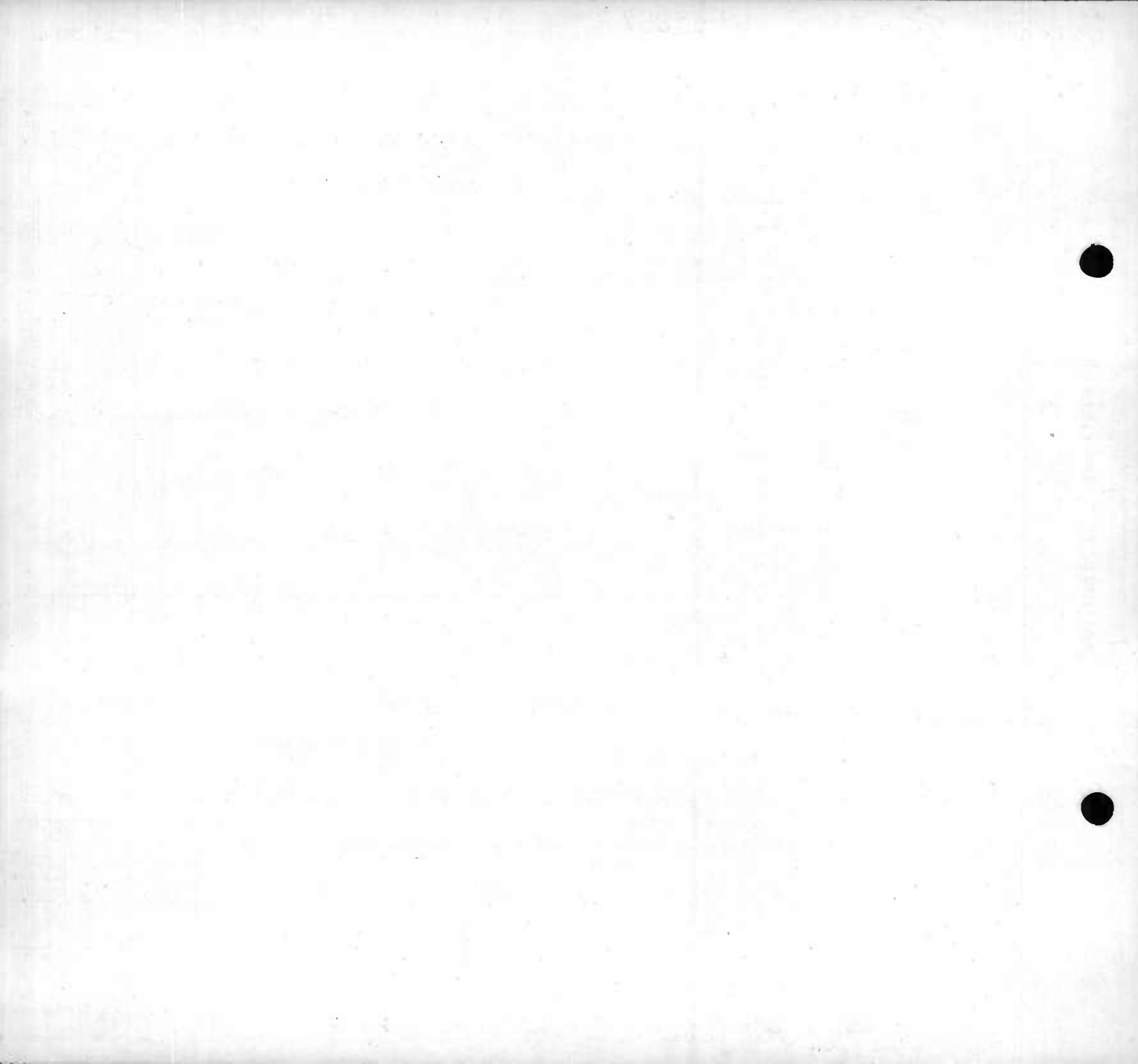
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

| BIRTH NO. 68-11967 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 68-11967 | |
|--|---------------------|---|-------------------------------------|---|--|--|---|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Turner Edwin H.</u> | | | | 2. DATE AND HOUR OF DEATH
<u>11/27/68</u> <u>12</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>43 South Baltimore General Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>1333 E. Patapsco Ave 21225</u> | | | |
| | | | | C. CITY OR TOWN
<u>Baltimore Md.</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10/23/02</u> | 9. AGE (In years last birthday)
<u>66</u> | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Transit Driver</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>TURNER, WALTER</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>FLORENCE BAKER MD</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-10-0195</u> | | 17. INFORMANT
<u>Ellen V. Turner 1333 E. Patapsco Ave 21225</u> | | | |
| 18. <u>4269 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>331X II</u> | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>Respiratory arrest</u>

(B) <u>Recurrent CVA Diffuse brain damage 7 years</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>Recurrent CVA</u> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>NOV 12</u> 19 <u>68</u> to <u>NOV 27</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> DEGREE | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>11/27/68</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Conrad T. Tsai MD</u> DEGREE | | | | 23D. ADDRESS
<u>South Baltimore General Hosp</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>11-30-68</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Cedar Hill Cem.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>A.A. Co. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 2 1968</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR
<u>McCall E.H. 237 Patapsco Ave 21225</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11968

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11968

| | | | | | |
|--|-------------------------|---|--|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) CAREY DANIEL BLAKE | | 2. DATE AND HOUR OF DEATH
NOV. 26, 1968 10:40 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE UNION MEMORIAL HOSP.
44 | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | E. STREET AND NUMBER
329 ILCHESTER AVE | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-05-05 | 9. AGE (In years last birthday)
63 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Manager | | 10B. KIND OF BUSINESS OR INDUSTRY
Magazine | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
JULIUS BLAKE | | 14. MOTHER'S MAIDEN NAME
GEORGIA BLAKE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
228-10 83 48 | | 17. INFORMANT
MARY BLAKE
CHART - 329 Ilchester Ave. - BALTO MD | |
| 18. 492X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CARDIO-RESPIRATORY FAILURE
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
CHRONIC EMPHYSEMA | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 DAYS
2 YRS. | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
527.1 II
OLD CVA | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-20 19 68 to 11-26 19 68 , that (I) (we) last saw the deceased alive on 11-26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Long T. Chua, MD | | | | 23B. DATE SIGNED
11-26-68 | |
| 23C. PHYSICIAN'S NAME (Type)
Long T. Chua, MD | | | | 23D. ADDRESS
UNION MEMORIAL HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/30/68 | | 24C. NAME OF CEMETERY or CREMATORY
Prospect Hill | |
| 24D. LOCATION (City, town, or county) (State)
Towson MD | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Wm. Cork, Byrds Jr. | |
| 25D. ADDRESS
1217 S. Bant St. Balto. MD 21202 | | | | | |

Julius Drake
Georgia Drake
Virginia

750000

GAO-10-423P

[illegible]

REV 3 423

[Handwritten notes and signatures]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

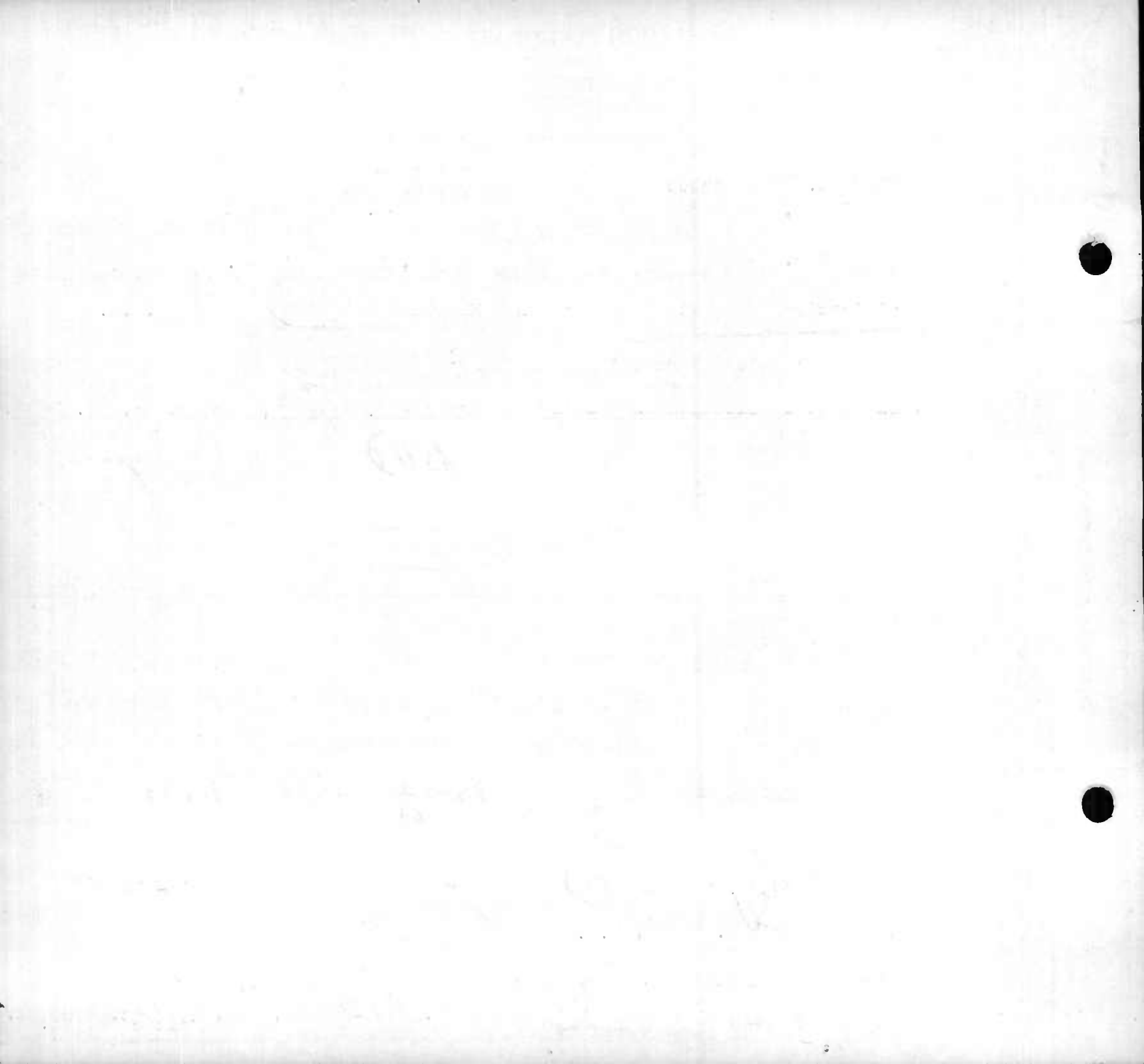
68-11969 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11969

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) MARY ELEANOR FARNANDIS | | 2. DATE AND HOUR OF DEATH
November 28, 1968 | | M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
1127 St. Paul Street
Baltimore, Maryland 21202 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
Female | | 6. RACE
Cau. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 4, 1898 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Rehabilitation | | 10B. KIND OF BUSINESS OR INDUSTRY
State Of Maryland | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Samuel Walter Farnandis | | | | 14. MOTHER'S MAIDEN NAME
Lilly Leonard | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-01-5480 | | 17. INFORMANT
Lillian F. Montell, Chestertown, Md. 21620 | | | |
| 18. 412.31 | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ASHD | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | | | years. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
420.0 II | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 22 19 68 to Nov 28 19 68 , that (I) (we) last saw the deceased alive on Nov 22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Francis M. Dugan, M.D. | | | | 23B. DATE SIGNED
11-29-1968 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Francis M. Dugan, M.D. | | 23D. ADDRESS | | 23E. FUNERAL DIRECTOR
Wm. Cook-Brooks, Inc. | | 23F. ADDRESS
1217 St. Paul St. Baltimore, Md. 21202 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-30-68 | | 24C. NAME OF CEMETERY or CREMATORY
Green Mount Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
Wm. Cook-Brooks, Inc. | | 25D. ADDRESS
1217 St. Paul St. Baltimore, Md. 21202 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11970 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11970

| | | | | | |
|---|----------------------|---|---|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Mrs. Alice Morrison | | 2. DATE AND HOUR OF DEATH
11-29-68 NOV. 29, 1968 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Hood Convalescent Home Inc. | | E. STREET AND NUMBER
5313 Edmondson Ave. | | | |
| 5. SEX
F. | 6. RACE
W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 26, 1873 | 9. AGE (In years last birthday)
95 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME
Dallas P. West | | 14. MOTHER'S MAIDEN NAME
Nancey L. West | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no none | | 16. SOCIAL SECURITY NO.
-- | | 17. INFORMANT
Mrs Elsie Walburn 27 Maple Ave. Catonsville | |
| 18. 412.41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
PNEUMONIA
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
DECUBITI' ULCERS, MULTIPLE
(B) ASCVD. | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
4-22-61 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from AUGUST 1968 to NOVEMBER 29, 1968 , that (I) was lost saw the deceased alive on 11/27 1968 and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
E. Kasaitis, M.D. | | 23B. DATE SIGNED
11/29/68 | | 23C. PHYSICIAN'S NAME (Type)
E. KASAITIS, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Dec 2, 1968 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
21228 | | 25D. ADDRESS
1801 FREDERICK RD, BALTIMORE MD | | 25E. ADDRESS
9736 Edmondson Ave. Catonsville, Md. 21228 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-400 68-11971 BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 68-11971 |
|---|--------------------------|--|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Daisy L. Bull</u> | | |
| 2. DATE AND HOUR OF DEATH | | <u>11-29-68</u> <u>10:30 P.</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <u>Md.</u> B. COUNTY <u>G. G. C. 52-00</u> | | |
| <u>48 Maryland Gen. Hospital</u> | | C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| <u>829 Linden, Balto, Md. 21201</u> | | E. STREET AND NUMBER <u>169 W. Meadow Rd.</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-23-89</u> | 9. AGE (In years last birthday) <u>79</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> |
| 13. FATHER'S NAME <u>William Leckliter</u> | | 14. MOTHER'S MAIDEN NAME <u>Rachel Alder</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Ada Cobey</u> ADDRESS <u>3212 Hilltop Ave. Balto, Md.</u> |
| 18. <u>599.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES | | (B) <u>Urinary tract infection</u> DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-12</u> <u>1968</u> to <u>11-29</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>11-29</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Delfa E. Young, M.D.</u> | | 23B. DATE SIGNED <u>11-29-68</u> | | 23C. PHYSICIAN'S NAME (Type) _____ |
| 23D. ADDRESS _____ | | 23E. DEGREE _____ | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE <u>12-3-68</u> | 24C. NAME of CEMETERY or CREMATORY <u>Hereford Baptist Cemetery</u> | 24D. LOCATION (City, town, or county) (State) <u>Parkton, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 2 1968</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> |

85-96-11

FUNERAL DIRECTOR: IMPORTANT

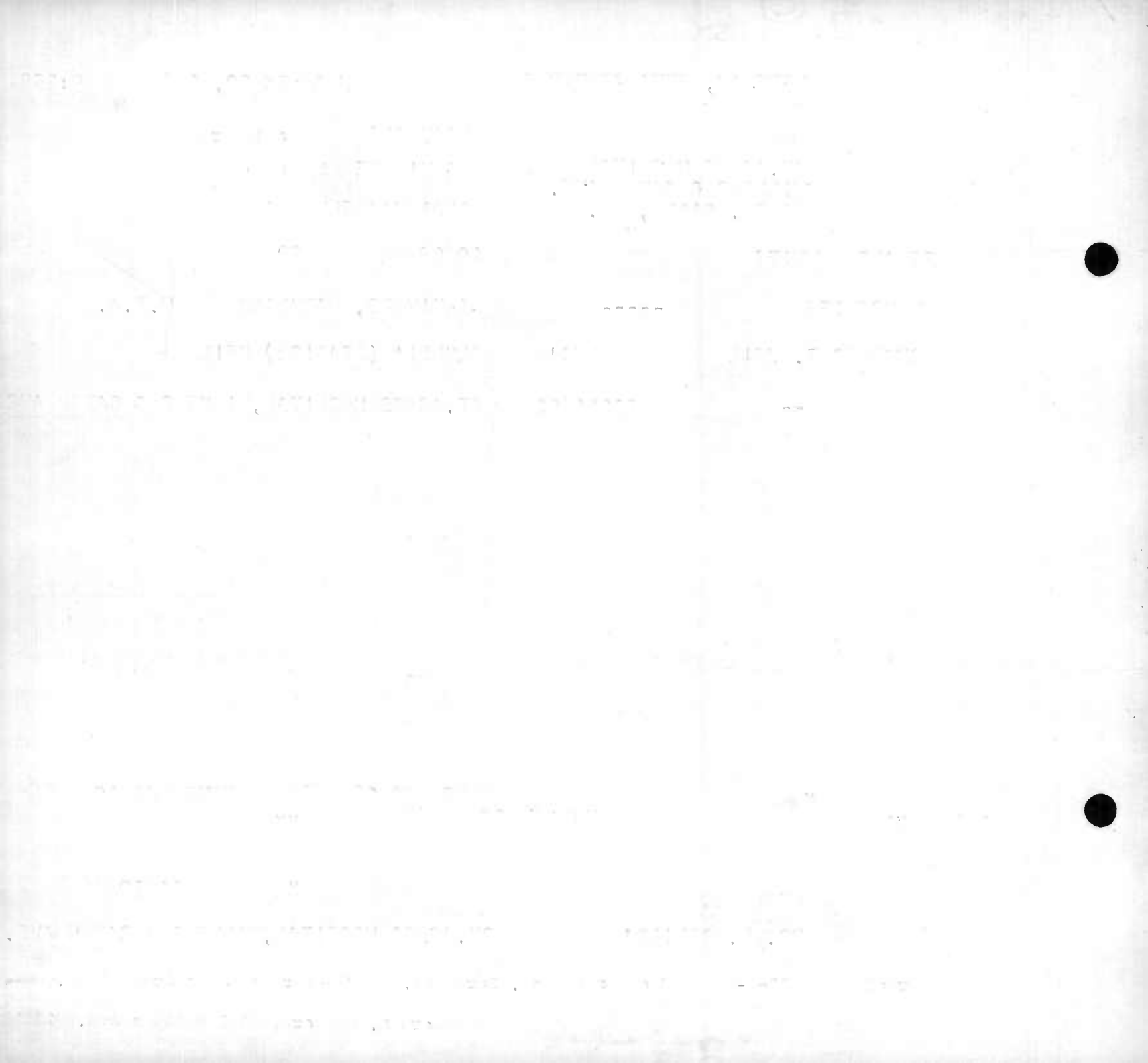
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11972 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-11972

| | | | | | |
|--|-----------|--|---|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | HOFFMAN, ETTA GERTRUDE | | NOVEMBER 30, 1968 9:25P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| ST. AGNES HOSPITAL
WILKENS & CATON AVE.
BALTO. 21229, MD. | | | MARYLAND Baltimore C 53-00 | | |
| C. CITY OR TOWN | | | D. INSIDE CITY LIMITS? | | |
| BALTIMORE, Highlands | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER | | | 2701 YARNELL ROAD | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| FEMALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 10/25/98 | 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | ----- | | BALTIMORE, MARYLAND | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| CHARLES F. KEIL | | | U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| NO -- | | | 212226229 | | ST. AGNES HOSPITAL, WILKENS & CATON AVE |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | ACUTE MYOCARDIAL INFARCTION | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE | | |
| ANTECEDENT CAUSES | | | DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | ARTERIOSCLEROTIC CARDIOVASCULAR | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | (B) HEART DISEASE | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) ----- | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 28 19 68 to NOVEMBER 30 19 68, that (X) (we) last saw the deceased alive on NOVEMBER 30 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| DR. R. REVILAA | | | | 11/30/68 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| DR. R. REVILAA | | | | ST. AGNES HOSPITAL, WILKENS & CATON AVE. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 12-4-68 | Glen Haven Mem. Park Cem. | | GlenBurnie, Anne Arundel Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 2 1968 | | Robert E. Jenkins | | Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 68-11973 | |
|---|--------------|---|--|--|--|
| 68-11973 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | WOJCIECHOWSKI
MARY D. WOJCIECHOWSKI | | NOVEMBER 28 1968 7:30 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00
I4II DUNDALK AVENUE | | | MARYLAND
C. CITY OR TOWN D. INSIDE CITY LIMITS?
BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER
I4II DUNDALK AVENUE | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 14-1880 | 9. AGE (In years last birthday)
88 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PICKLE PACKER | | 10B. KIND OF BUSINESS OR INDUSTRY
LANGS PICKLE CO | | 11. BIRTHPLACE (State or foreign country)
POLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
MARTIN DROZD | | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
217-05-3052 | | 17. INFORMANT ADDRESS
MRS FRANCES MICHNO I4II DUNDALK AVENUE | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerosis C.V. Dis 6 Mo | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF:
Rheumatoid Arthritis 8 yrs | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 60 to Nov 28 19 68, that (I) (we) last saw the deceased alive on Nov 20 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Stephen C. Mackowiak | | | | 23B. DATE SIGNED
II-29-68 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. STEPHEN C. MACKOWIAK | | | | 23D. ADDRESS
6714 HOLABIRD AVENUE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
I2-2-1968 | | 24C. NAME of CEMETERY or CREMATORY
HOLY ROSARY CEMETERY | |
| | | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Tachy | | 25C. FUNERAL DIRECTOR ADDRESS
WALTER DABROWSKI 1005 DUNDALK AVENUE | |

68-11974

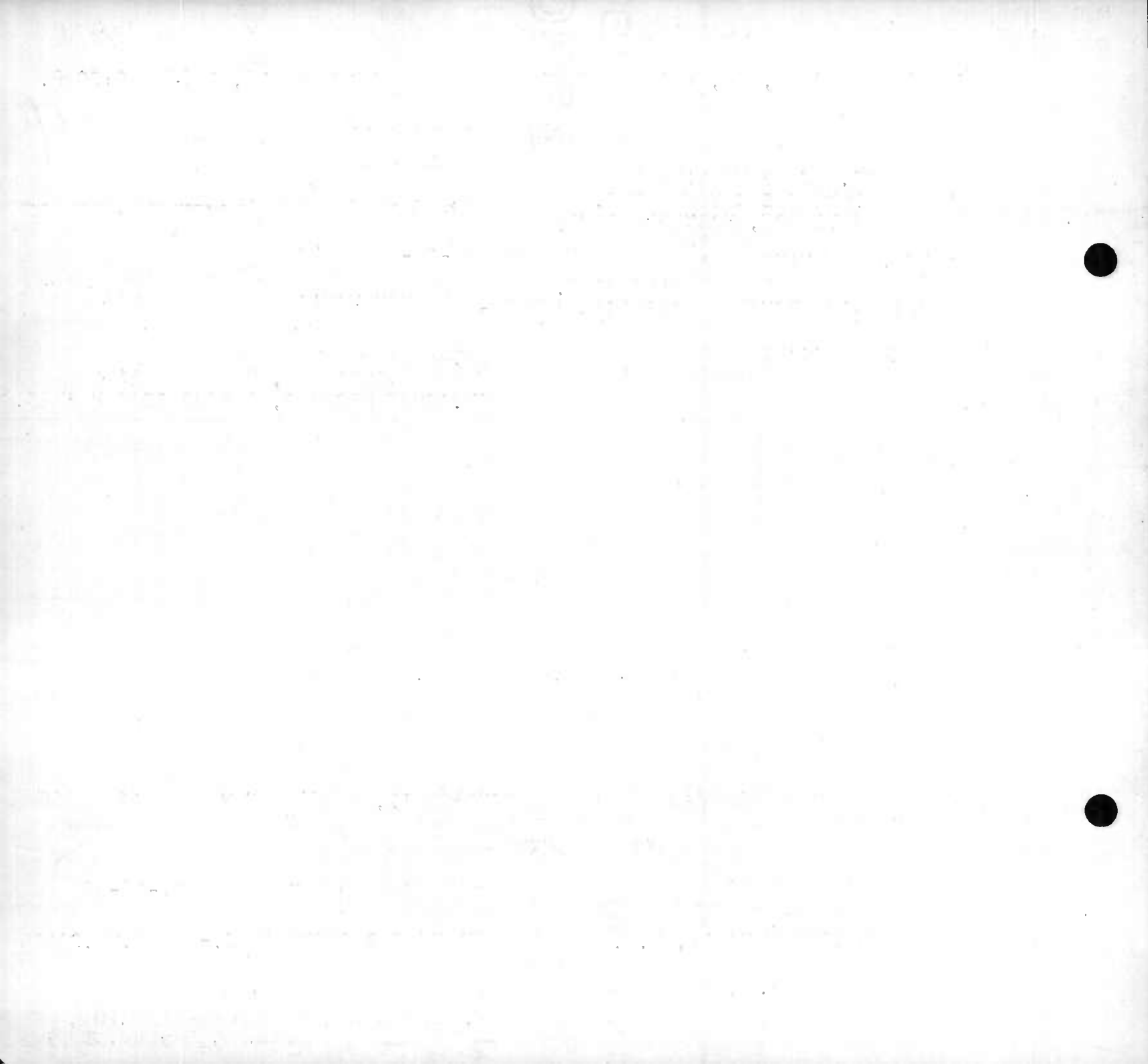
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11974

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) MCCABE, SR, OLIVER LEROY | | 2. DATE AND HOUR OF DEATH
NOVEMBER 26, 1968 10:00 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND 21229
B. COUNTY | | 28-04 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 ST. AGNES HOSPITAL
WILKENS & CATON AVES.
BALTIMORE, MARYLAND 21229 | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
506 GLEN ALLEN DRIVE | | 5. SEX
MALE | | 6. RACE
WHITE | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
07-28-09 | | 9. AGE (In years lost birthday)
59 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RADIO DISPATCHER | | 10B. KIND OF BUSINESS OR INDUSTRY
BILE ASSN.
AMERICAN AUTOMO- | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
OLIVER MCCABE | | 14. MOTHER'S MAIDEN NAME
Barbara Knuth | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
BALTIMORE, MARYLAND 21229
ST. AGNES RECORDS, WILKENS & CATON AVES. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.)
198.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
Metastatic Carcinoma
(Primary site not determined)
198.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
193.0 II | | 20. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. DATE OF OPERATION
11-23-68 | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cranio tomy & Tracheostomy | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from OCTOBER 12, 1968 to NOVEMBER 26, 1968, that (X) (we) last saw the deceased alive on NOVEMBER 26, 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Hamid | | 23B. DATE SIGNED
11-26-68 | | 23C. PHYSICIAN'S NAME (Type)
MEHDIZADEH HAMID, M.D. | |
| 23D. ADDRESS
WILKENS & CATON AVES.-BALTO.MD.21229 | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Nov.30,1968 | |
| 24C. NAME OF CEMETERY or CREMATORY
Western Cemetery | | 24D. LOCATION
(City, town, or county) Baltimore, Maryland | | 24E. STATE
(State) Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Feltner | | 25C. FUNERAL DIRECTOR
G. Truman Schwab, 5151 Baltimore Natl. Pike, Baltimore, Maryland, 21229 | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11975

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

VERNON

F.

ALTVATER

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 26, 1968

12:05 P.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospital

3. DATE

Month

Day

Year

Hour

November 26, 1968

12:05 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

white

B. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

9. DATE OF BIRTH

June 7, 1904

10. AGE (In years
lost birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

7622 Spruce Road

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Charles Altvater

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Agent

14B. KIND OF BUSINESS OR INDUSTRY

Railway Express

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

?

18. INFORMANT

ADDRESS

Mrs. Bernadine Culatta, 5 Cassandra Ct, Randalstown Md.

19.

141.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Carcinoma of Tongue

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

141.9 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/26/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Nov. 29, 1968

24C. NAME of CEMETERY or CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 2 1968

25B. NAME OF REGISTRAR

Robert E. Janney, M.D.

25C. FUNERAL DIRECTOR

G. Truman Schwab, 3512 Frederick Ave., Baltimore
Maryland, 21228

ADDRESS

50

4

WALL LEM

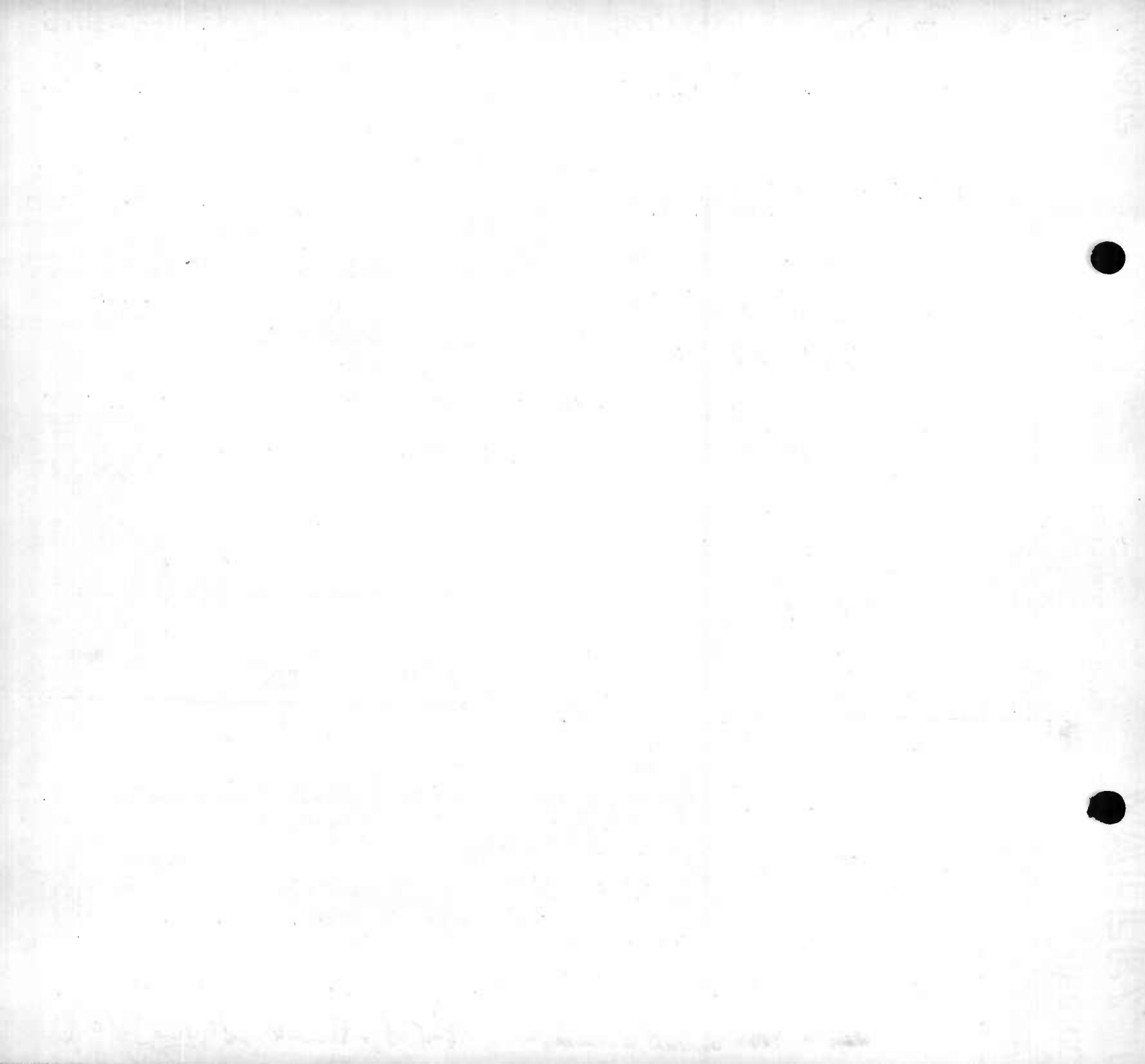
51-96-21

djs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------|--|------------------|---|------------------------------|---|--|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | | 68-11976 | |
| 1. NAME OF DECEASED
(Type or Print) | | Elmer Gibbons | | 2. DATE AND HOUR OF DEATH | | 11/27/68 5:30 a.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | Maryland | | SOMERSET Co. 69-00 | |
| Baltimore City Hospital | | 4940 EASTERN AVE. BALTO. MD. 21224 | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | Westover | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER | | Route 1, Box 186-A | | 21871 | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. CITIZEN OF WHAT COUNTRY? | | |
| MALE | WHITE | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 3/26/92 | 76 | U.S.A. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| U.S.C.G. YARD | | RIGGER | | MARYLAND | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| CHARLES H. GIBBONS | | SUSAN HART | | 217-14-5770 A | | BCH: RECORDS 4940 EASTERN AVE. BALTO. MD. 21224 | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | Lymphosarcoma | | 1 year | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 21. INJURY OCCURRED | | 22. I certify that (I) (this hospital) attended the deceased from 10/25 1968 to 11/27 1968, that (I) (we) last saw the deceased alive on 11/27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 24. NAME OF CEMETERY or CREMATORY | | 25. FUNERAL DIRECTOR | |
| Albert B. Einstein Jr. MD. | | 11/27/68 | | FAIRVIEW LAWN | | Robert A. Beranico, Severna Park | |
| 26. PHYSICIAN'S NAME (Type) | | 27. ADDRESS | | 28. LOCATION (City, town, or county) | | (State) | |
| Albert B. Einstein Jr. MD. | | 4940 EASTERN AVE. BALTO. MD. 21224 | | ONANCOCK, VA | | | |
| 29. DATE REC'D BY HEALTH DEPT. | | 30. NAME OF REGISTRAR | | 31. DATE OF OPERATION | | 32. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| DEC 2 1968 | | Robert E. Taylor | | 2 | | | |
| 33. DATE OF OPERATION | | 34. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 35. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 36. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 37. DATE OF OPERATION | | 38. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 39. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 40. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 41. DATE OF OPERATION | | 42. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 43. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 44. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 45. DATE OF OPERATION | | 46. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 47. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 48. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 49. DATE OF OPERATION | | 50. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 51. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 52. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 53. DATE OF OPERATION | | 54. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 55. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 56. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 57. DATE OF OPERATION | | 58. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 59. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 60. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 61. DATE OF OPERATION | | 62. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 63. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 64. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 65. DATE OF OPERATION | | 66. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 67. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 68. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 69. DATE OF OPERATION | | 70. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 71. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 72. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 73. DATE OF OPERATION | | 74. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 75. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 76. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 77. DATE OF OPERATION | | 78. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 79. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 80. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 81. DATE OF OPERATION | | 82. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 83. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 84. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 85. DATE OF OPERATION | | 86. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 87. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 88. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 89. DATE OF OPERATION | | 90. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 91. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 92. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 93. DATE OF OPERATION | | 94. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 95. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 96. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |
| 97. DATE OF OPERATION | | 98. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 99. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 100. WHERE DID INJURY OCCUR? | |
| 2 | | | | | | In Baltimore City, give exact location | |

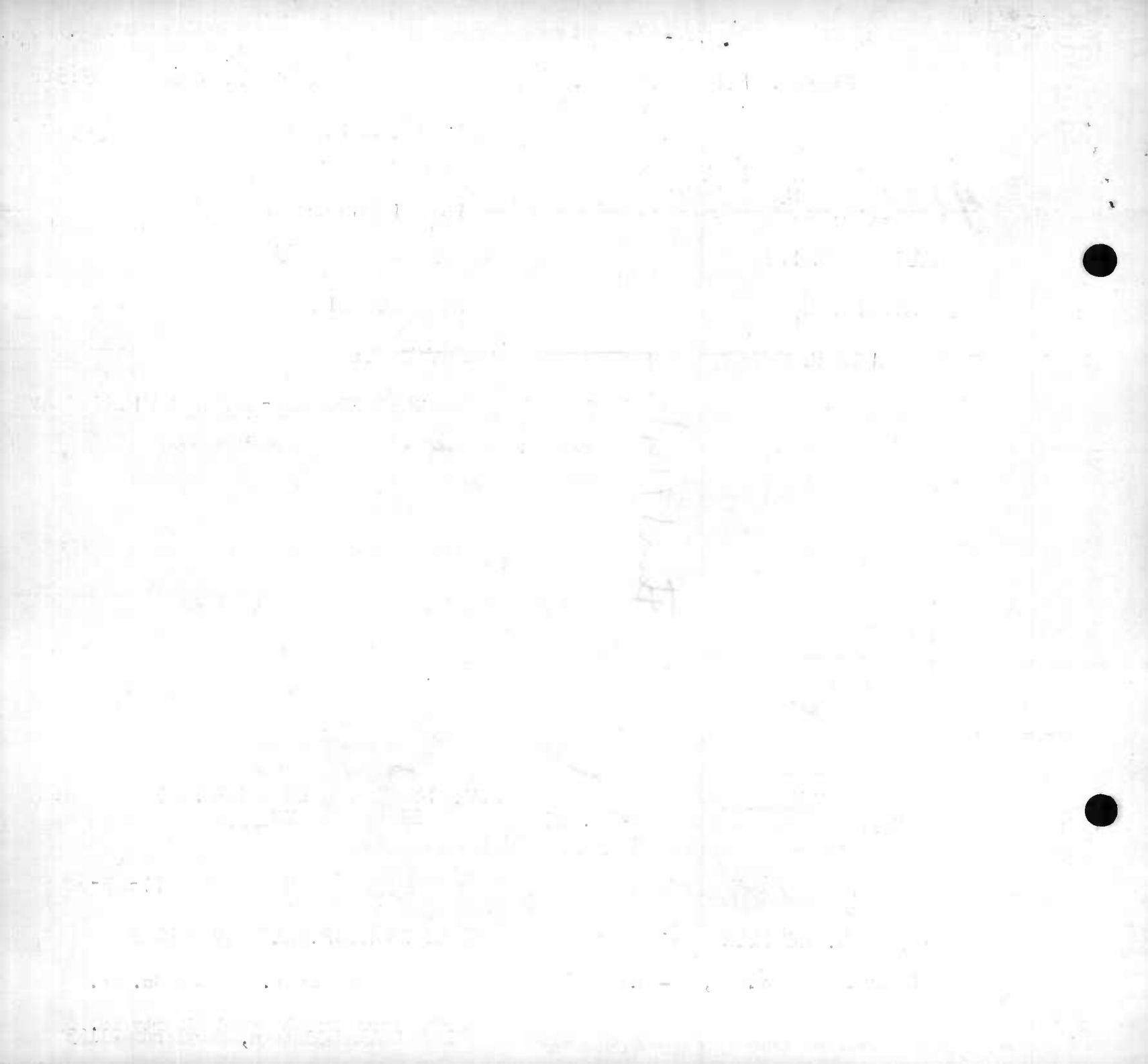


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 68-11977 | |
|--|----------------------|--|----------------------------------|---|---|
| BIRTH NO. 1. NAME OF DECEASED
(Type or Print) FRANK PHILIP DWYER SR. | | 2. DATE AND HOUR OF DEATH
NOVEMBER 27, 1968 9:50P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
ST AGNES HOSPITAL
CATON & WILKENS AVE
BALTIMORE, MARYLAND 21229 | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE PENNSYLVANIA
B. COUNTY RENNO
C. CITY OR TOWN RENNO
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 165 SIXTH STREET | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 03 82 | 9. AGE (In years lost birthday) 85 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PHYSICIAN | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U S A | | 13. FATHER'S NAME
MICHAEL DWYER | | 14. MOTHER'S MAIDEN NAME
MARY NAGLE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
82302887 | | 17. INFORMANT ADDRESS
ST AGNES RECORDS-CATON & WILKENS AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
PROBABLE PULMONARY EMBOLISM | | CAUSE OF DEATH
PROBABLE PULMONARY EMBOLISM | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
E903.6 II | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
PROTHROMBIC FRACTURE OF THE FEMUR | | | |
| 19A. DATE OF OPERATION
11-14-68 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Fracture of hip | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) office | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Renovo, Pa. | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
11-13-68 ? | | 21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Slipped on ice | |
| 22. I certify that <u>XIX</u> (this hospital) attended the deceased from <u>NOV. 14</u> 19 <u>68</u> to <u>NOV. 27</u> 19 <u>68</u> , that <u>X</u> (we) last saw the deceased alive on <u>NOV. 27</u> 19 <u>68</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X We) (did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | 23B. DATE SIGNED
11-27-68 | | 23C. PHYSICIAN'S NAME (Type)
R. REVILLA | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
Nov. 27, 68 | | 24C. NAME of CEMETERY or CREMATORY
St. Joseph Cem | |
| 24D. LOCATION (City, town, or county) (State)
Hyder Pa. Clinton Co. Pa. | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR
Loring Byers Chapel | | 25D. ADDRESS
8728 Liberty Rd | | 25E. ADDRESS
Randallstown, Maryland 21133 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11978

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11978

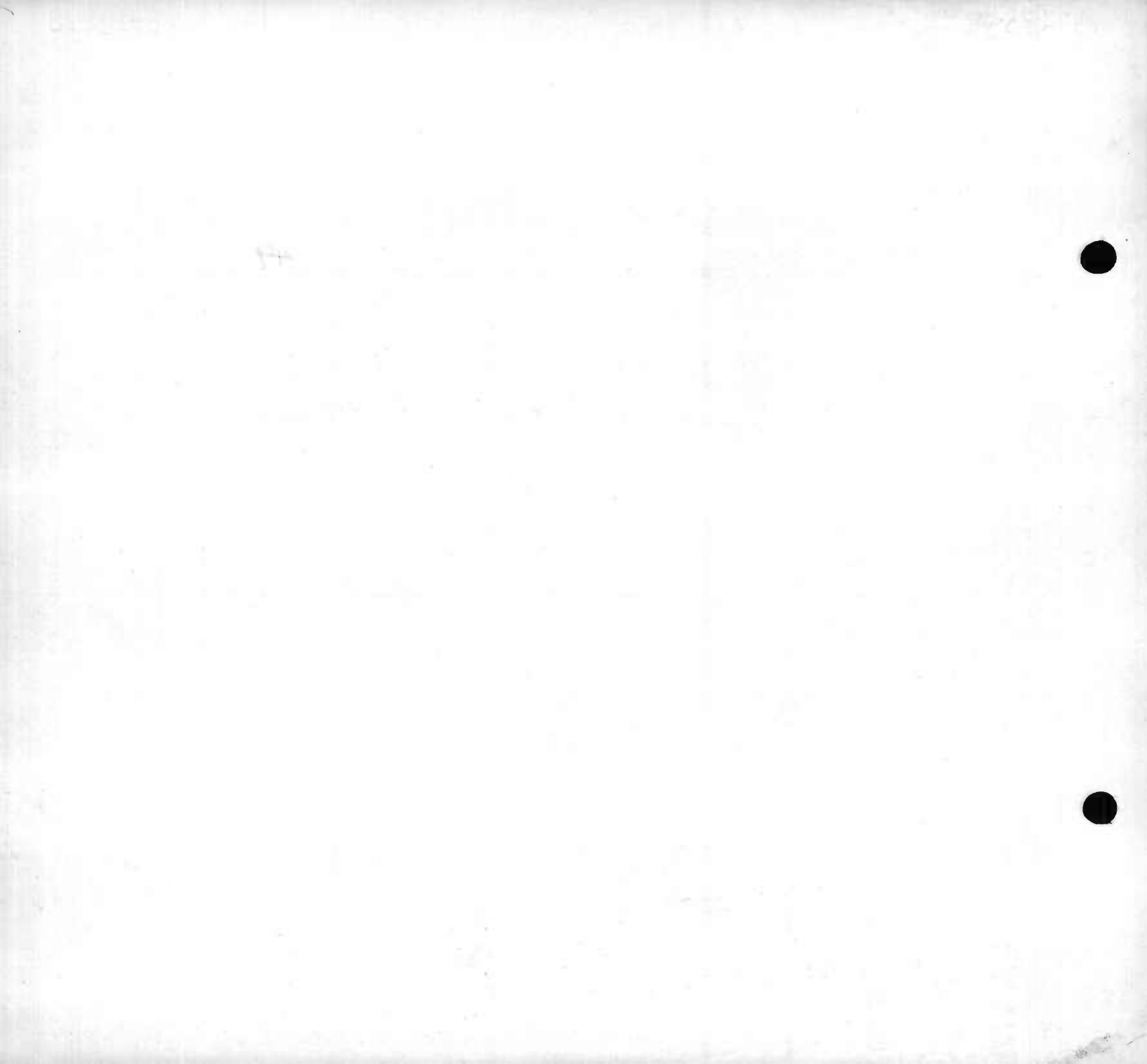
| | | | | | |
|---|-----------------------------|--|-------------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print)
<i>JOHN S. BRANAM</i> | | 2. DATE AND HOUR OF DEATH
<i>11/28/68 5 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
<i>MD.</i>
8. COUNTY | | CITY OR TOWN
<i>BALTIMORE MD</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>UNION MEMORIAL HOSPITAL</i>
<i>33RD & CALVERT STS. BALT MD</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
<i>MALE</i> | 6. RACE
<i>CAUCASIAN</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>10/28/19</i> | 9. AGE (In years last birthday)
<i>49</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Mechanic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>AUTO.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>TENN</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 13. FATHER'S NAME
<i>John S. Branam Sr.</i> | | 14. MOTHER'S MAIDEN NAME
<i>Nancy Brooks</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>yes II</i> | | 16. SOCIAL SECURITY NO.
<i>410-09-2669</i> | | 17. INFORMANT
<i>Mrs. Phillip Branam</i> | |
| 18. <i>4319 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<i>331X II</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<i>CEREBRAL HEMORRHAGE</i>
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

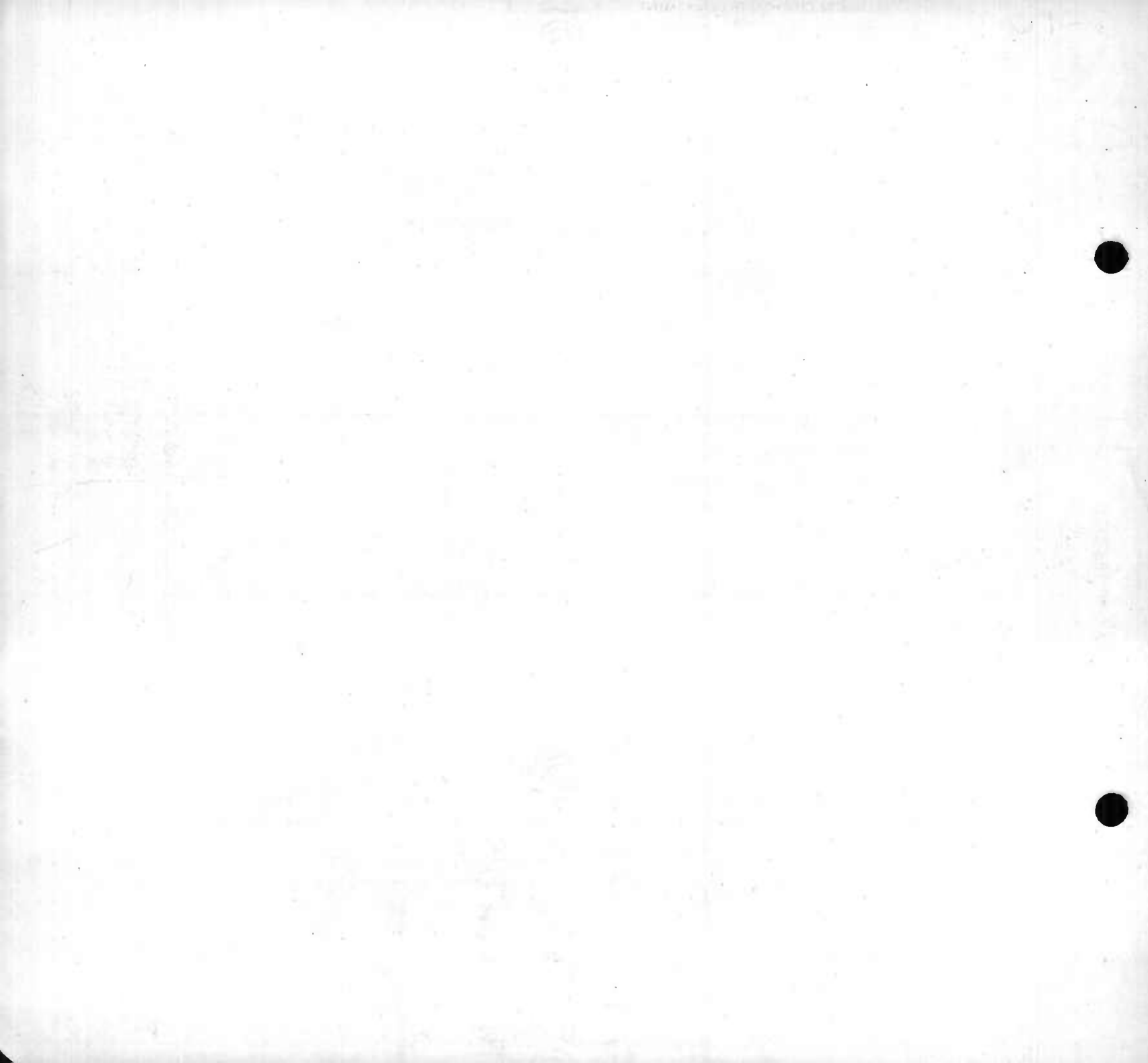
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/28</i> 19 <i>68</i> to <i>11/28</i> 19 <i>68</i> that (I) (we) last saw the deceased alive on <i>11/28</i> 19 <i>68</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Ronald M. Legum</i> | | 23B. DATE SIGNED
<i>11/28/68</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>RONALD M. LEGUM</i> | |
| 23D. ADDRESS
<i>Union Memorial Hospital Balt MD</i> | | 23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 23F. ATTENDING PHYS. <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>12/3/68</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Balt. Nat. Cem.</i> | |
| 24D. LOCATION
<i>BALT MD.</i> | | 24E. CITY, TOWN, OR COUNTY | | 24F. STATE | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 2 1968</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR
<i>Frank Phillips 322 S. High St.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|
| 68-11578 | | | | | REG. NO. 68-11578 | | | | | | | | | |
| BIRTH NO. | | | | | 1. NAME OF DECEASED
(Type or Print) <i>Schiavo Anthony P</i> | | | | | 2. DATE AND HOUR OF DEATH
<i>11/25/68 804 P.M.</i> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>MD</i> B. COUNTY <i>BALTO</i> | | | | | 5. CITY OR TOWN <i>BALTO</i> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>38 Univ Hospital</i> | | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | 6. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 7. SEX <i>M</i> | | | | | 8. RACE <i>W</i> | | | | | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>High Checker</i> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Retail</i> | | | | | 11. BIRTHPLACE (State or foreign country)
<i>MD</i> | | | | |
| 13. FATHER'S NAME
<i>Anthony Schiavo</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>MARY</i> | | | | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)
<i>No</i> | | | | | 16. SOCIAL SECURITY NO.
<i>217-07-2273</i> | | | | | 17. INFORMANT
<i>Mrs Marie Schiavo</i> | | | | |
| 18. <i>492X1</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the made at dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>congestive heart failure</i> | | | | | CAUSE OF DEATH | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>Emphysema</i> | | | | | (B) <i>Emphysema</i>
DUE TO, OR AS A CONSEQUENCE OF: | | | | | (C) _____ | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<i>527.1 II</i> | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/18/68</i> to <i>11/25/68</i> and that (I) (we) last saw the deceased alive on <i>11/25/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE
<i>ES Caplan MD</i> | | | | | 23B. DATE SIGNED
<i>11/25/68</i> | | | | | 23C. PHYSICIAN'S NAME (Type)
<i>ES Caplan MD</i> | | | | |
| 23D. ADDRESS
<i>Univ Hosp</i> | | | | | 23E. DATE REC'D BY HEALTH DEPT.
<i>DEC 2 1968</i> | | | | | 23F. NAME OF REGISTRAR
<i>Robert E. Farber</i> | | | | |
| 23G. FUNERAL DIRECTOR
<i>Frank Della Voce</i> | | | | | 23H. ADDRESS
<i>322 St. High</i> | | | | | 23I. NAME OF CEMETERY or CREMATORY
<i>Holy Redeemers</i> | | | | |
| 23J. LOCATION (City, town, or county) (State)
<i>BALTO MD</i> | | | | | 23K. DATE OF BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | | | 23L. DATE
<i>11/29/68</i> | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11980 CERTIFICATE OF DEATH

REG. NO. 68-11980

| | | | | | |
|--|--|---|---|---|---|
| BIRTH NO. <u>68-11980</u> | | 1. NAME OF DECEASED
(Type or Print) <u>HOWARD R. GALLAGHER</u> | | 2. DATE AND HOUR OF DEATH
<u>11/26/68 10¹⁰ P. M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
<u>CERTIFICATE ATTENDED</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>24-02</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>NORTH CHARLES GEN HOSP.</u> | | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
<u>24-02</u> <input type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>M</u> 6. RACE <u>W</u> | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>9-23-1900</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>WATCHMAN</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>ST. PD. Comm.</u> | | 9. AGE (In years lost birthday)
<u>68</u> |
| 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 13. FATHER'S NAME
<u>JOHN GALLAGHER</u> | | | 14. MOTHER'S MAIDEN NAME
<u>LOUELLA A. GALLAGHER</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | | 16. SOCIAL SECURITY NO.
<u>213-05-5332A</u> | | 17. INFORMANT
<u>HOSPITAL CHART</u> |
| 18. <u>434.1 II</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>Chronic congestive heart failure</u>
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>15 months</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | (A) IMMEDIATE CAUSE <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
(B) <u>CHRONIC CONGESTIVE HEART FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>POS. CHRONIC BRONCHITIS OF LUNG (SUSPECT)</u> | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> 19 <u>68</u> to <u>11/26</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/26</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> | | | | 23B. DATE SIGNED
<u>11/26/68</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>MARYLAND A. TOLENTINO</u> | | | | 23D. ADDRESS
<u>NORTH CHARLES GEN. HOSP.</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
<u>2</u> | | 24B. DATE
<u>11/30/68</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Green Hill</u> | |
| 24D. LOCATION
<u>Balto.</u> | | 24E. DATE REC'D BY HEALTH DEPT.
<u>DEC 2 1968</u> | | 24F. NAME OF REGISTRAR
<u>[Signature]</u> | |
| 24G. FUNERAL DIRECTOR
<u>[Signature]</u> | | 24H. ADDRESS
<u>[Address]</u> | | 24I. DATE
<u>DEC 2 1968</u> | |

Letter from Dr. Mariano A. Tolentino, North
Charles General Hospital 12-9-68 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 68-11981 | |
|---|---------|--|------------------|--|---|
| 68-11981 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | |
| | | | | James S. Burton | |
| 2. DATE AND HOUR OF DEATH | | 11/25/68 P. 555 p.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY | | | |
| FULL NAME OF (If not in hospital or institution, give street address or location)
INSTITUTION | | PA. 17943 | | | |
| THE JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
LAVELLE | | | |
| 601 N. BROADWAY,
BALTIMORE 21205 Md. | | D. STREET ADDRESS (If rural, give location)
11 HONEYCOMB ROAD | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. Under 1 Yr.
Months Days Hours Min. |
| MALE | WHITE | WIDOWER | 08 14 89 | 79 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| COAL MINER | | | | KENTUCKY | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| WILLIAM H. BURTON | | MOLLIE STANLEY BURTON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| UNK | | 403-09-1580 | | WM. BURTON 11 HONEYCOMB RD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 162.1 I | | (A) Respiratory arrest | | 3 months | |
| ANTECEDENT CAUSES | | (B) metastatic carcinoma of lung to brain. | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| 165X II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Nov. 19 1968 to Nov. 25 1968, that (1) (we) last saw the deceased alive on Nov 25 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| DAVID B. CASE | | | | 11/25/68 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| DAVID B. CASE | | THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 11/27/68 | | GARDENS OF FAITH | |
| | | | | BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 2 1968 | | Robert E. Tarkenton | | J.E. CONNELLY SONS 300 MACE | |

James S. Gifford

Aug 22 1892

A. J. Gifford

James S. Gifford

James S. Gifford

James S. Gifford

James S. Gifford

James S. Gifford

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James S. Gifford

James S. Gifford

Registering a vessel

Registering a vessel
of the State of New York

NY

3 months

McKen

Nov 32

Nov 32

Nov 32

11/2/92

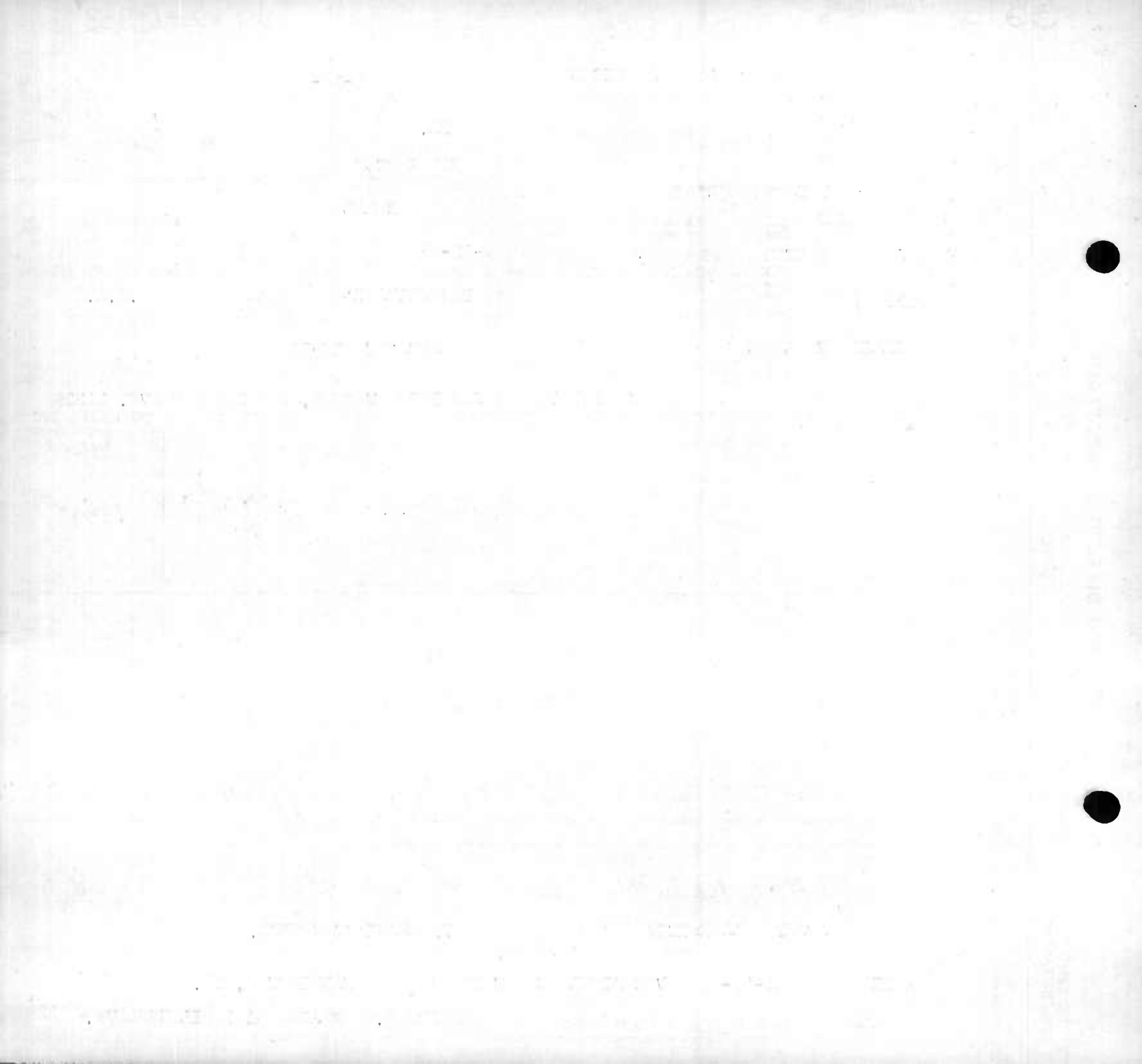
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11982 CERTIFICATE OF DEATH

REG. NO. **68-11982**

| | | | | | |
|--|-------------------------|---|--|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) ELIZABETH VAN SICKLE | | 2. DATE AND HOUR OF DEATH
11-26-68 4th P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE PA. B. COUNTY V-35 | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 806 PRIMSON AVENUE | | C. CITY OR TOWN
FARMINGTON | |
| | | | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
RURAL | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6-13-81 | 9. AGE (In years last birthday) 87 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOMEMAKER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | |
| 13. FATHER'S NAME
WILLIAM FAULKNER | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14. MOTHER'S MAIDEN NAME
MARGARET MINNIS | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | |
| 16. SOCIAL SECURITY NO.
266387979 | | 17. INFORMANT ADDRESS
JOSEPHINE TURNER, 806 PRIMSON AVE. 21229 | | | |
| 18. 409 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Cerebral Hemorrhage | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerotic Cardio Vascular Renal Disease | | (B) DUE TO, OR AS A CONSEQUENCE OF:
10 yrs | |
| (C) _____ | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
442 X II | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/8/58 19 68 to now 19 68 , that (I) (we) last saw the deceased alive on 11/26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joseph L. Laukaitis | | | | 23B. DATE SIGNED
11/27/68 | |
| 23C. PHYSICIAN'S NAME (Type)
JOSEPH LAUKAITIS | | | | 23D. ADDRESS
679 WASHINGTON BLVD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
11-29-68 | | 24C. NAME of CEMETERY or CREMATORY
VAN SICKLE CEMETERY | |
| 24D. LOCATION
FARMINGTON, PA. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | | |
| 25B. NAME OF REGISTRAR
Robert E. [Signature] | | 25C. FUNERAL DIRECTOR
HOWARD H. HUBBARD | | 25D. ADDRESS
4107 WILKENS AVE. 21229 | |



5-420

68-11983 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11983

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOHN

D.

SOLES

2. DATE
OF
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

November 25, 1968

8:30 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 26, 1968

1:20 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2110 St. Paul St.

6. SEX

male

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

9. DATE OF BIRTH

2-12-1928

10. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ace Soles

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mittie Proctor

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

WWII

17. SOCIAL
SECURITY NO.

246-20-8499

18. INFORMANT

ADDRESS

Mildred McGirt, 4433 So. 31st St. Arlington Va.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Cirrhosis of Liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

581.0

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes (Partial)

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/26/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-29-68

24C. NAME OF CEMETERY OR CREMATORY

Millican Cemetery

24D. LOCATION (City, town, or county)

Whiteville, North Carolina

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

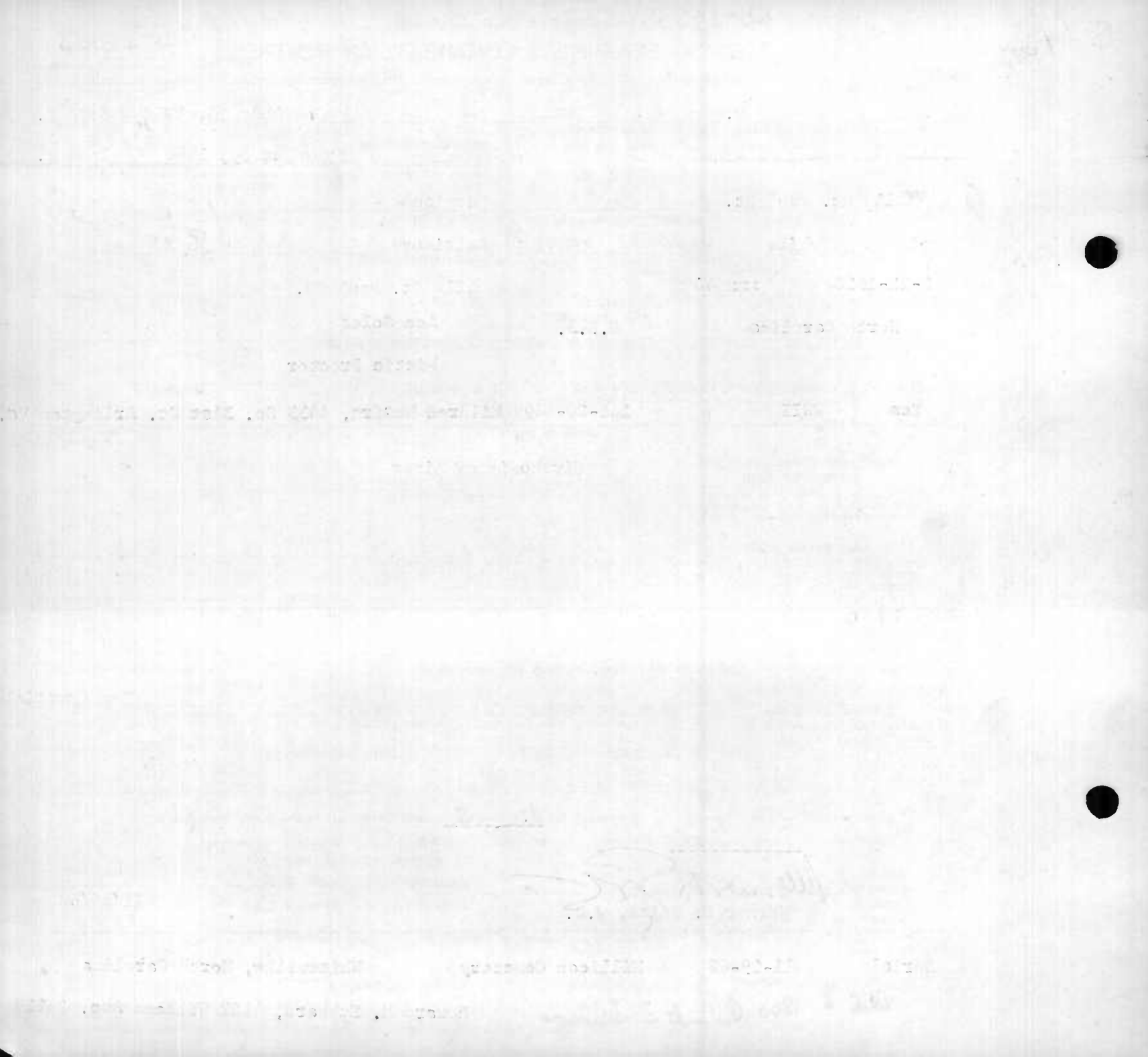
25C. FUNERAL DIRECTOR

ADDRESS

DEC 2 1968

Robert E. Hubbard

Howard H. Hubbard, 4107 Wilkens Ave. 21229



1
P-452

68-11984 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11984

| | | | | | |
|---|-------------------------|--|---|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) HAROLD GEORGE POLING | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month 11 Day 27 Year 68 Hour 8:00 a M.
Estimated <input type="checkbox"/> | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
43 South Baltimore General Hospital | | 3. DATE PRONOUNCED DEAD
Month November Day 27 Year 1968 Hour 8:00 a M. | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | |
| 6. SEX
Male | 7. RACE
White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN
Balto. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH
12-26-1931 | | 10. AGE (In years lost birthday)
36 | E. STREET AND NUMBER
609 S. Smallwood St. | | |
| 11. BIRTHPLACE (State or foreign country)
West Virginia | | 12. CITIZEN OF
U. S. A. | 13. FATHER'S NAME
Lloyd Poling | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Maintenance Mechanic | | 14B. KIND OF BUSINESS OR INDUSTRY
Eastern Products | | 15. MOTHER'S MAIDEN NAME
Ethel Camel | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes Korean | | 17. SOCIAL SECURITY NO.
218-28-0877 | | 18. INFORMANT
Patricia A. Poling ADDRESS Balto. 21223 | |
| 19. 412.4 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH
Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 20A. DATE OF OPERATION
0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
No | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23.
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Edward F. Wilson M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED November 27, 1968 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-30-68 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore City, Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Farber | |
| 25C. FUNERAL DIRECTOR
Howard H. Hubbard | | 25D. ADDRESS
4107 Wilkens Ave. 21229 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **68-11985**

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) ZELLA P Penley | | 2. DATE AND HOUR OF DEATH
11/25/68 1 5⁰⁰ P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE PENNSYLVANIA B. COUNTY 11-35 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL
33 | | C. CITY OR TOWN
GLENROCK, 17327 | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
129 CHURCH ST | | 5. SEX
FEMALE | | 6. RACE
WHITE | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8-18-20 | | 9. AGE (In years lost birthday)
48 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Scott Co. Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
NOBLE PETERS | | 14. MOTHER'S MAIDEN NAME
MARGARET LANE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
445-16-7186 | | 17. INFORMANT
Roy J. Penley ADDRESS 129 Church St. Glen Rock, Pa. | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
MYOCARDIAL INFARCTION
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
① Mitral valve Regurgitation - ② 34 days | | 19. 420.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 DAYS | |
| 19A. DATE OF OPERATION
10/21/68 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Mitral valve disease | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NO | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 10/12 19 68 to 11/25 19 68 , that (I) (we) last saw the deceased alive on 11/25 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Howard C. Swider Jr. MD. DEGREE | | 23B. DATE SIGNED
11/25/68 | | 23C. PHYSICIAN'S NAME (Type)
HOWARD C SWIDER JR MD DEGREE | |
| 23D. ADDRESS
Johns Hopkins Hospital, Baltimore | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/29/68 | |
| 24C. NAME OF CEMETERY or CREMATORY
Mt. Prospect | | 24D. LOCATION (City, town, or county) (State)
Seven Valleys, York Co. Pa. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | |
| 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR
James J. Hartenstein | | ADDRESS
New Freedom, Pa. | |

Handwritten text, possibly a name or title.

Scott Co. Va. 1862

42-11-1862 Roy J. P. King, Esq.

128 Church St. Sta. Louis, Mo.

10/31/68

422

11/2/68

11/2/68

Howard C. Zuercher, Esq. John Taylor

11/2/68 Mt Prospect

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>68-11986</u> | |
|--|-------------------------|--|-------------------------------------|---|---|
| BIRTH NO. <u>68-23056</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. <u>68-23056</u> | | 1. NAME OF DECEASED
(Type or Print) <u>Baby girl Snow</u> | | 2. DATE AND HOUR OF DEATH
<u>11-21-68</u> <u>11</u> <u>40</u> <u>A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Johns Hopkins Hospital</u>
<u>33</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>8-A</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> <u>INSIDE CITY LIMITS</u>
D. STREET ADDRESS (If rural, give location)
<u>1637 E. NORTH AVE.</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Single</u> | 8. DATE OF BIRTH
<u>11-20-68</u> | 9. AGE (In years last birthday)
<u>1</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME
<u>MARY FRANCES SNOW</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <u>038.4 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>Sepsis</u>
DUE TO
(B) <u></u>
DUE TO
(C) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. <u>053.4 II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Possible intracranial hemorrhage</u> | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
III in Baltimore City, give exact location | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-20</u> <u>19 68</u> to <u>11-21</u> <u>19 68</u> , that (I) (we) last saw the deceased alive on <u>11-21</u> <u>19 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Frank A Simon</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>11-21-68</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>FRANK A. SIMON</u> | | 23D. ADDRESS
<u>Johns Hopkins Hospital Baltimore Md 21205</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>CREMATION</u> | | 24B. DATE
<u>11-21-68</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>THE JOHNS HOPKINS HOSP. BALTIMORE, MD.</u> | |
| 24D. LOCATION
<u>BALTIMORE, MD.</u> | | 24E. CITY, town, or county | | (State) | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
<u>DEC 2 1968</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Sanborn</u> | | 25C. FUNERAL DIRECTOR
<u>HOSPITAL DISPOSAL</u> | |
| ADDRESS | | | | | |

MEMORANDUM 11-21-68 THE JOHN HOPKINS HHS BALTIMORE, MD.

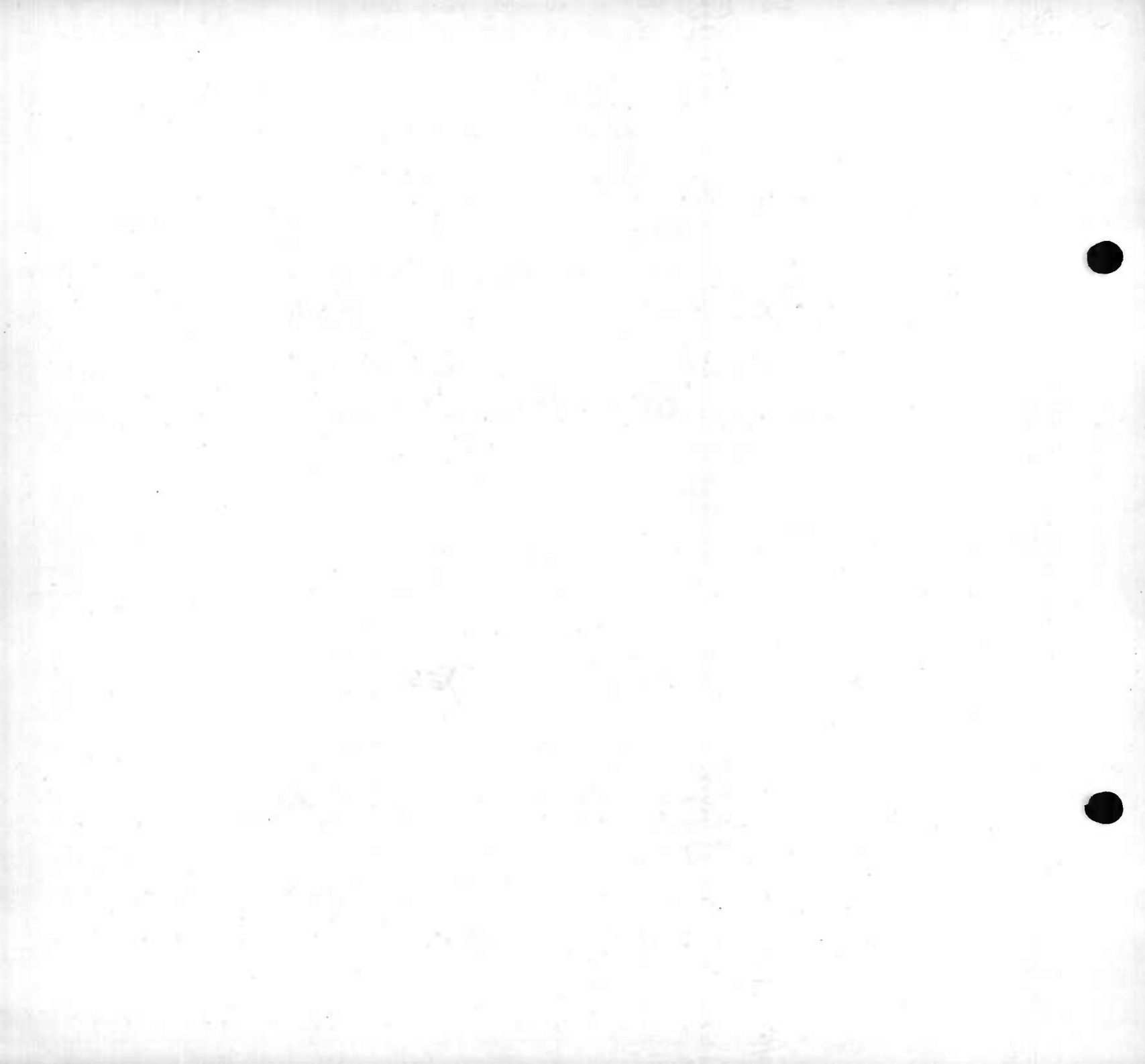
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11987 CERTIFICATE OF DEATH

REG. NO. 68-11987

| | | | | | |
|--|-----------|---|--|--|------------------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Samuel Johnson | | 2. DATE AND HOUR OF DEATH
1 Dec 1968 11:00 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
University of Maryland Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
516 N. Stricker St. | | | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8/1/10 | 9. AGE (In years last birthday) 58 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Freight Handler | | 10B. KIND OF BUSINESS OR INDUSTRY
Transfer Co | | 11. BIRTHPLACE (State or foreign country)
South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Charles Johnson | | | |
| 14. MOTHER'S MAIDEN NAME
Gale Sylvia | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service
NO | | 16. SOCIAL SECURITY NO.
250-22-9416 | |
| 17. INFORMANT
Chart | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
436.9 I
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Cerebral infarct
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 19. DATE OF OPERATION
17 Oct 68 | | 20. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 30 Oct 68 to 1 Dec 68, that (I) (we) last saw the deceased alive on 30 Oct 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Edward J. Layne | | 23B. DATE SIGNED
1 Dec 1968 | | 23C. PHYSICIAN'S NAME (Type)
Edward J. Layne | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
12/4/68 | | 24C. NAME OF CEMETERY or CREMATORY
Davis | |
| 24D. LOCATION
Furnessville S.C. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Marshall B. Taylor 638 N. G. C. M. St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11988 CERTIFICATE OF DEATH

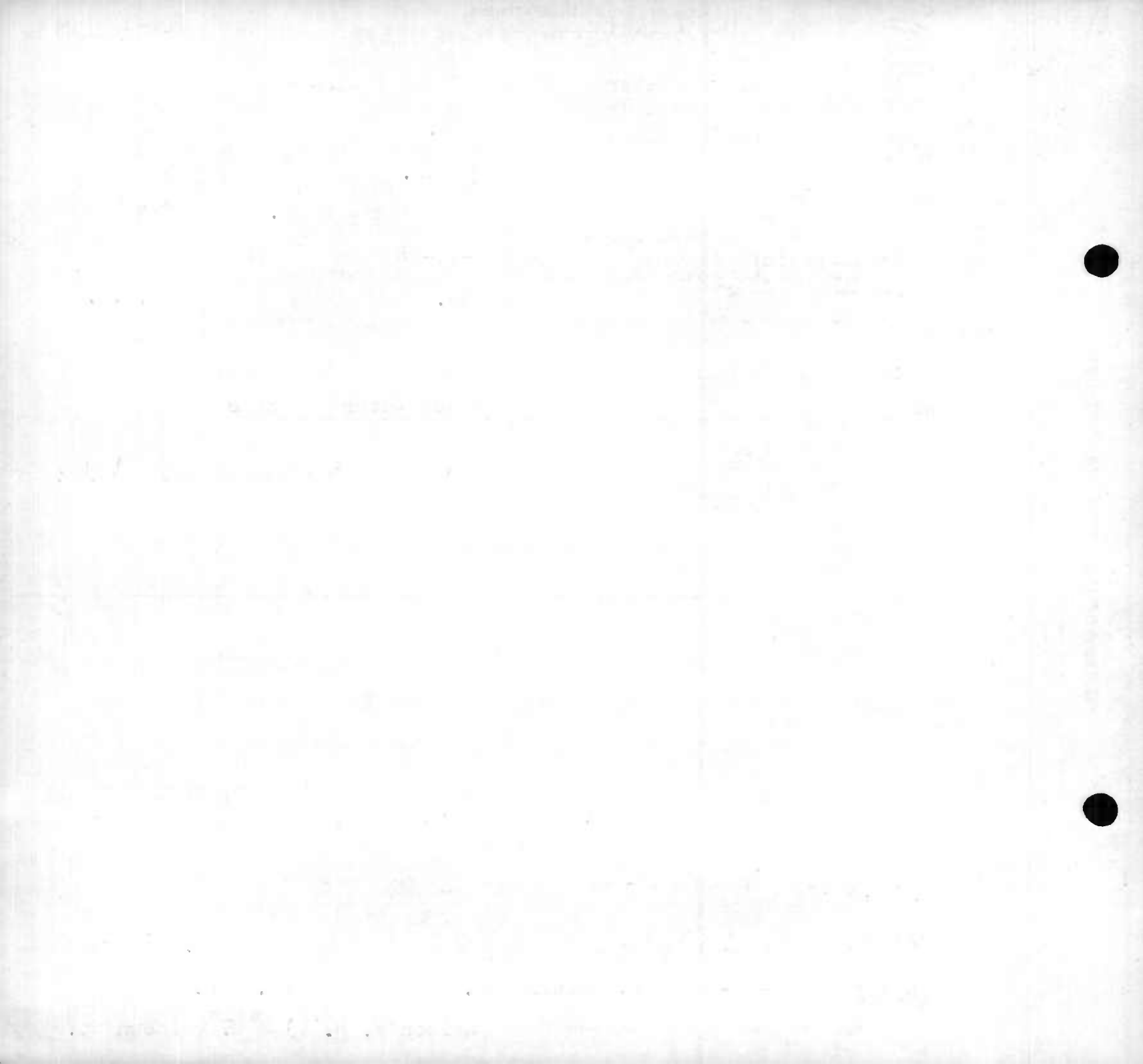
REG. NO. 68-11988

| | | | | | | | |
|--|---------------------------|---|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Linwood Jeter | | 2. DATE AND HOUR OF DEATH
11-26-68 | | M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
537 Presstman Street | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY 14-03 | | | |
| | | | | C. CITY OR TOWN
Balto. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
537 Presstman St. | | | |
| 5. SEX
Male | 6. RACE
Negroid | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9-15-98 | | 9. AGE (In years last birthday) 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Grace Jeter | | ADDRESS
same | |
| 18. 151.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
gastric carcinoma 1 year | | | |
| | | | | (B) _____
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) _____ | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
151X II | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-16 1968 to 11-26 1968 , that (I) (we) last saw the deceased alive on 11-16 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
William L. Watts
DEGREE | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
William L. Watts
DEGREE | | | | 23D. ADDRESS
5141 Arington Ave
2321 Home Ave
21222 | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-30-68 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
V.B. Bailey
Kelson F. H. | | ADDRESS
1348 N. Calhoun St. | |

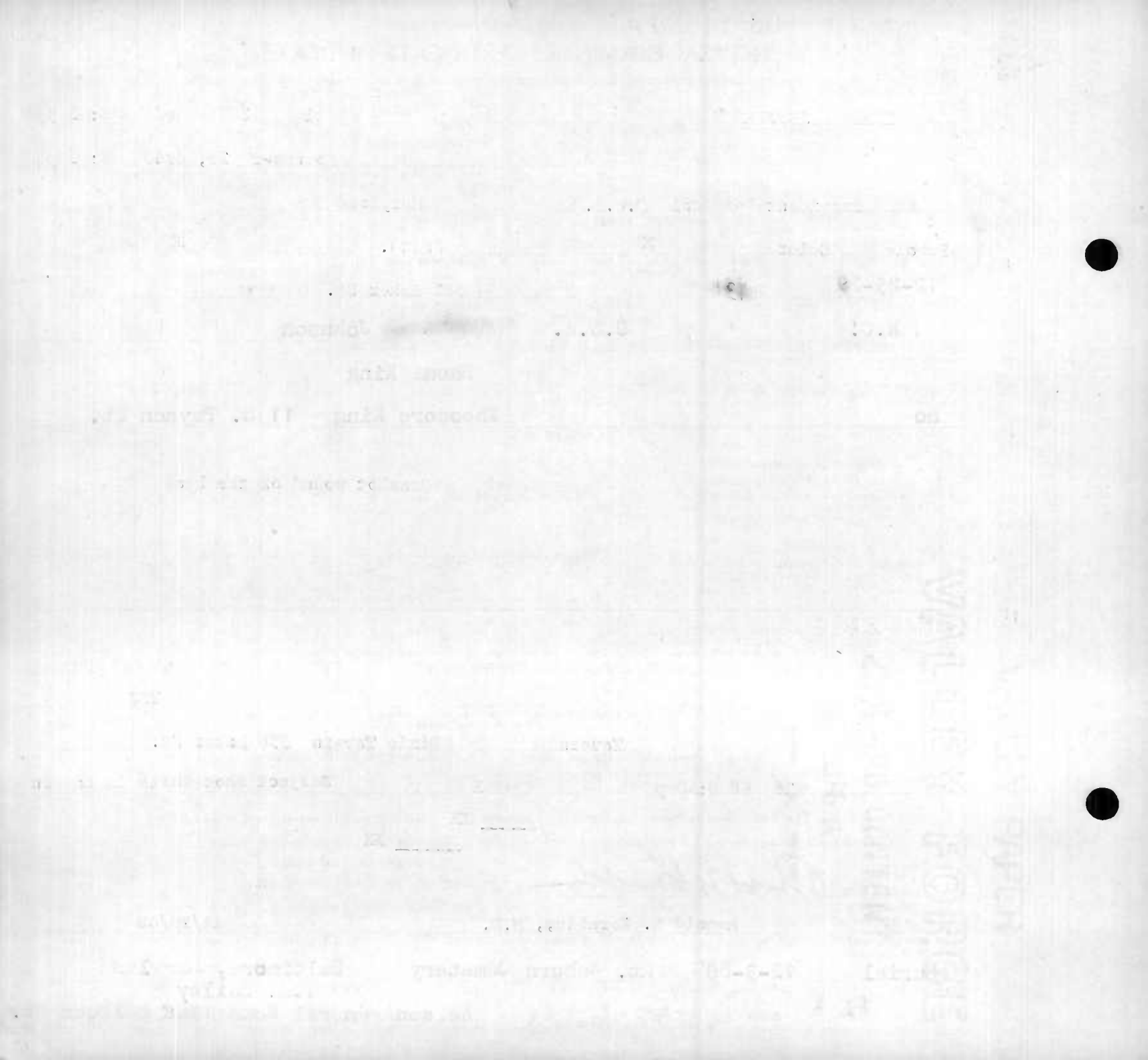


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
MINNIE JEFFERSON | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
11 28 68 8:45 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
Provident Hospital D.O.A. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
November 28, 1968 8:45 p.m. | |
| 6. SEX
Female | | 7. RACE
Colored | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
12-25-29 | | 10. AGE (In years lost birth date)
38 | |
| 11. BIRTHPLACE (State or foreign country)
N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME
Naomi King | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Theodore King | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
E965X | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Gunshot wound of the head
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
(C) _____ | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
YES | | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Tavern | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
<input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Dixie Tavern 558 Baker St. | |
| 22D. TIME OF INJURY (APPROX.)
Month Day Year Hour
11 28 68 8:30 p | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR?
Subject shot while in tavern | | 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE
Ronald N. Kornblum
EXAMINER'S NAME (Type)
Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12-3-68 | |
| 24C. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 1 1968 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
V.R. Bailey | | 25D. ADDRESS
Kelson Funeral Home 1348 Calhoun St. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11990

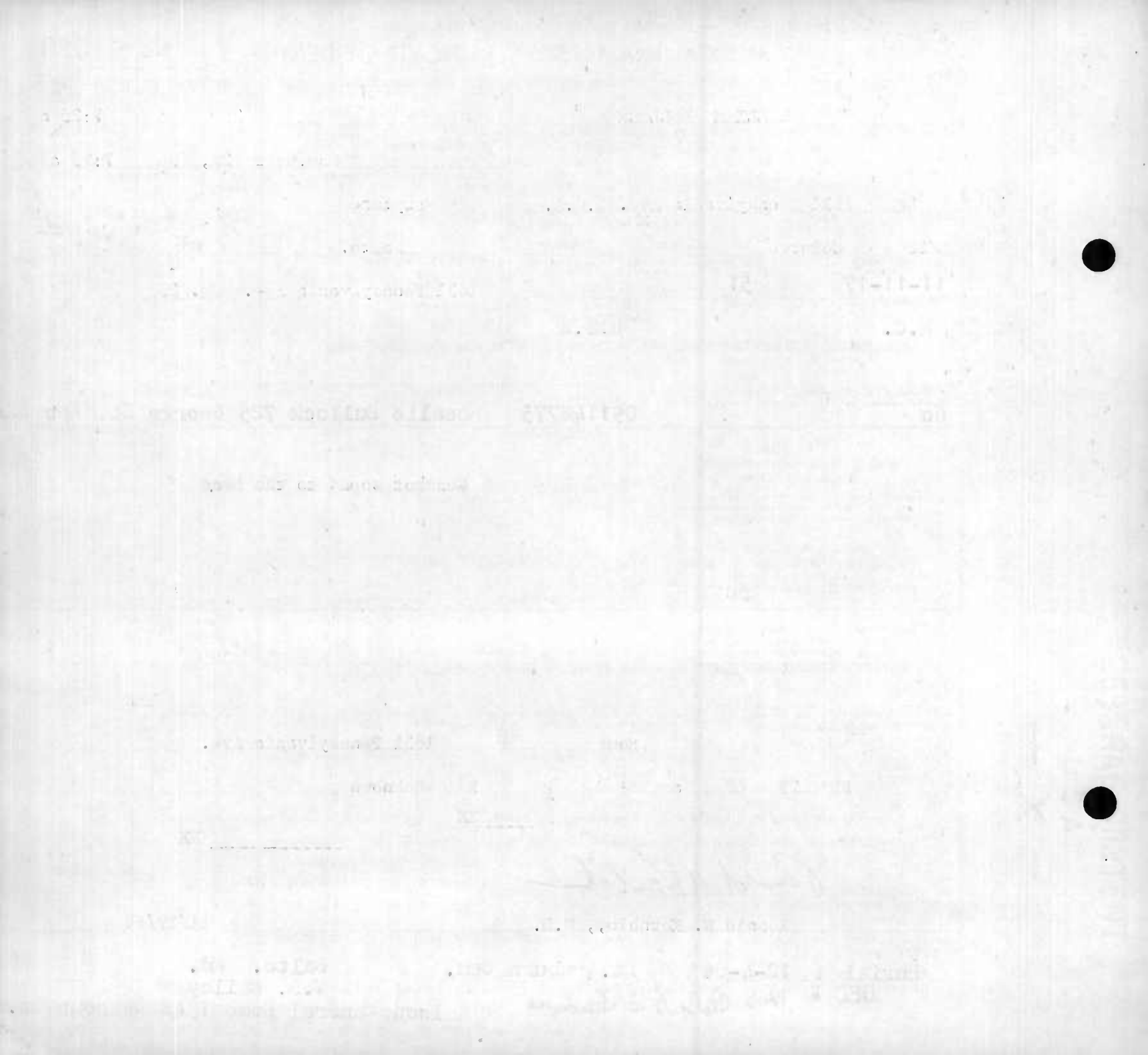
BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
WILLIAM BULLOCK | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
11 29 68 7:25 a. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
1631 Pennsylvania Ave. D.O.A. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
November 29, 1968 7:25 a.m. | |
| 6. SEX
Male | | 7. RACE
Colored | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
11-11-17 | | 10. AGE (In years last birthday) 51
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 17. SOCIAL SECURITY NO.
091142775 | |
| 18. INFORMANT
Rosalie Bullock | | ADDRESS
725 George St. Apt 12A | |
| 19. E9851X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE Gunshot wound to the head
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | |
| 22D. TIME OF INJURY (APPROX.)
Month Day Year Hour
11 29 68 a.m. | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
1631 Pennsylvania Ave. | | 22F. HOW DID INJURY OCCUR?
Unknown | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | 21. AUTOPSY? (Yes or No)
YES | |
| ACTUAL SIGNATURE
Ronald N. Kornblum
EXAMINER'S NAME (Type)
Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
11/29/68 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12-4-68 | |
| 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Farkner | |
| 25C. FUNERAL DIRECTOR
V.R. Bailey | | ADDRESS
Kelson Funeral Home 1348 Calhoun St. | |



B-650

68-11991 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11991

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MARY BROWN

2. DATE OF DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

11

28

68

6:20 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital D.O.A.

3. DATE PRONOUNCED DEAD

November 28, 1968

6:20 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Female

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

9. DATE OF BIRTH

6-29-28

10. AGE (In years last birthday)

40

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1023 N. Wolfe St.

11. BIRTHPLACE (State or foreign country)

VA.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

LAYTON BROWN

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

DOMESTIC

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lucy Sherman

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Lucy Sherman 905 B. Madison

19. CAUSE OF DEATH

E9651X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Gunshot wound of brain
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

E981X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

2

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

1023 N. Wolfe St.

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

11 28 68 5:40 p.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject shot in her home

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/29/68

24A. BURIAL CREMATION, REMOVAL (Specify)

Removal

24B. DATE

12/2/68

24C. NAME OF CEMETERY or CREMATORY

Forest Hill

24D. LOCATION (City, town, or county) (State)

Lynchburg, VA.

25. DATE RECEIVED BY HEALTH DEPT.

DEC 8 1968

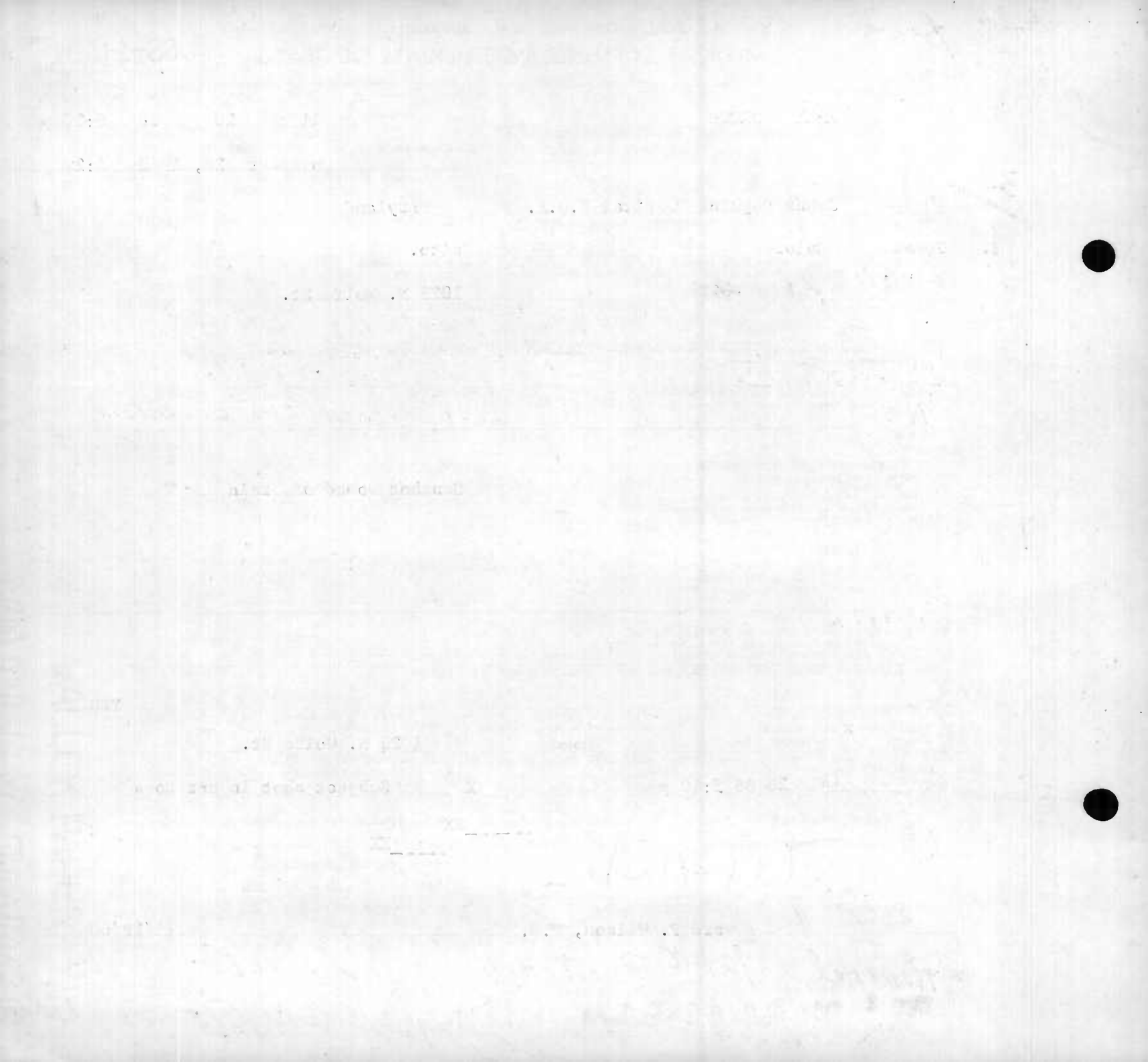
25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

Joseph B. Locks, Jr. 1304 N. Central Ave.

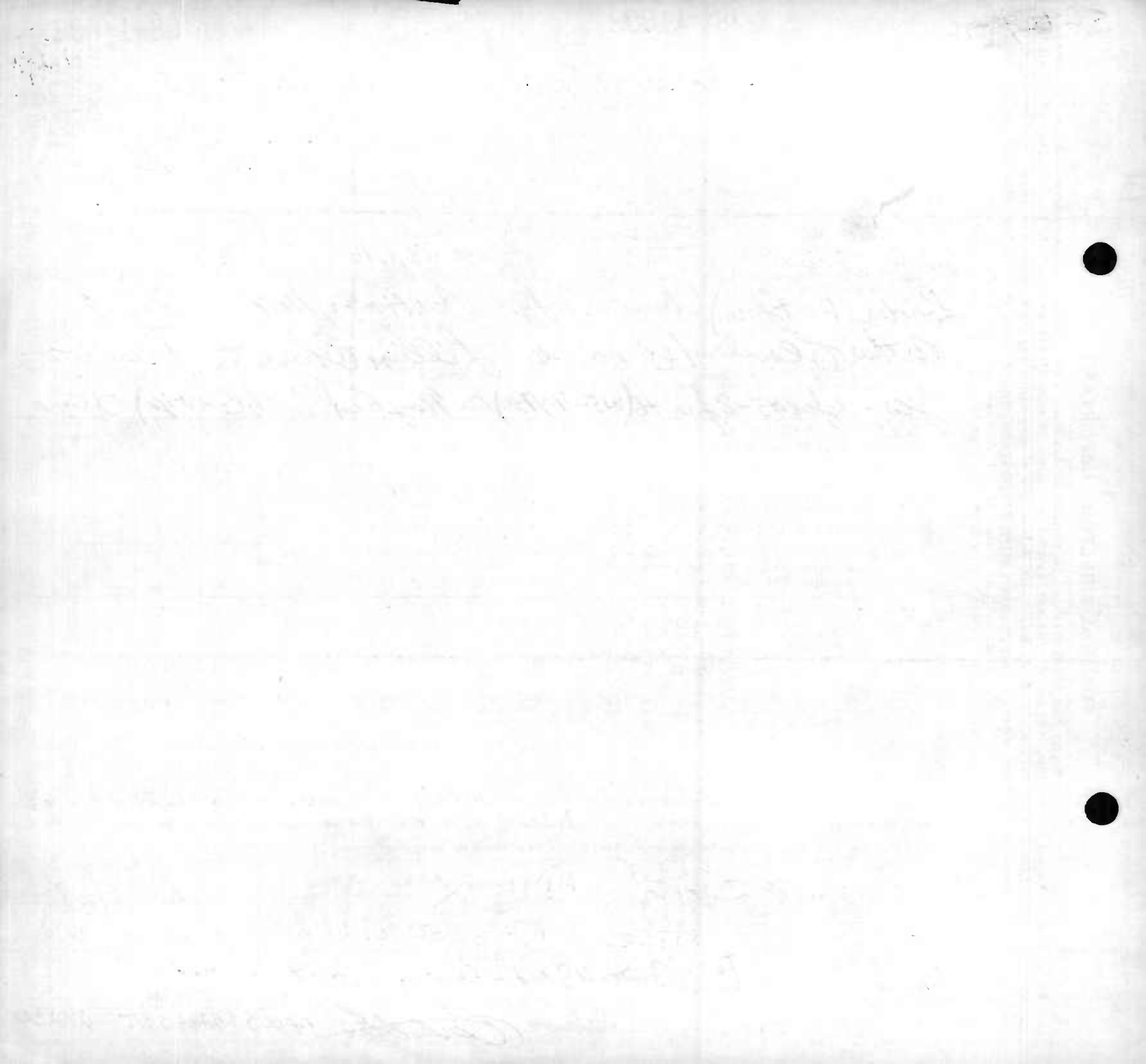
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 68-11992 |
|---|-------------------------|--|---|---|
| 68-11992 | | | | CERTIFICATE OF DEATH |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) JOHN EDWARD SCHIZBLE, Sr. | | |
| 2. DATE AND HOUR OF DEATH
SAT. NOV. 29, 1968 | | M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 23-02 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SOUTH BALTIMORE GENERAL HOSP. | | C. CITY OR TOWN BALTIMORE (21230) D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER
10 E. GITTINGS ST. | | | | |
| 5. SEX
Male | 6. RACE
White | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 28, 1916 | 9. AGE (In years last birthday) 52 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Leader (Plant form) Chemical Mfg. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | |
| 13. FATHER'S NAME
Arthur Cleveland Schizble | | 14. MOTHER'S MAIDEN NAME
Lillian Charlotte Trumbo | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes - 6 Jul 45 - 8 Jan 46 | | 16. SOCIAL SECURITY NO.
(215-09-9730) | | 17. INFORMANT
Mrs. Mary E Schizble (Wife) |
| 18. 4-10-91 | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
coronary artery thrombosis | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ASCVD
DUE TO, OR AS A CONSEQUENCE OF: | | |
| (C) _____ | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
42041 II | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from April 1968 to Nov 29, 1968 , that (I) (we) last saw the deceased alive on Nov 29, 1968 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Eugenio E Benitez | | 23B. DATE SIGNED
Dec 2/68 | | |
| 23C. PHYSICIAN'S NAME (Type)
EUGENIO E BENITEZ | | 23D. ADDRESS
MD 3350 Wilkens Ave Balto md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Dec 3-1968 | | 24C. NAME OF CEMETERY or CREMATORY
Bethesda U.S. Nat'l Cemetery |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 8 1968 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
CURTIS E. EVANS |
| ADDRESS
14005 CHARLES ST. 21230 | | | | |



FUNERAL DIRECTOR: IMPORTANT

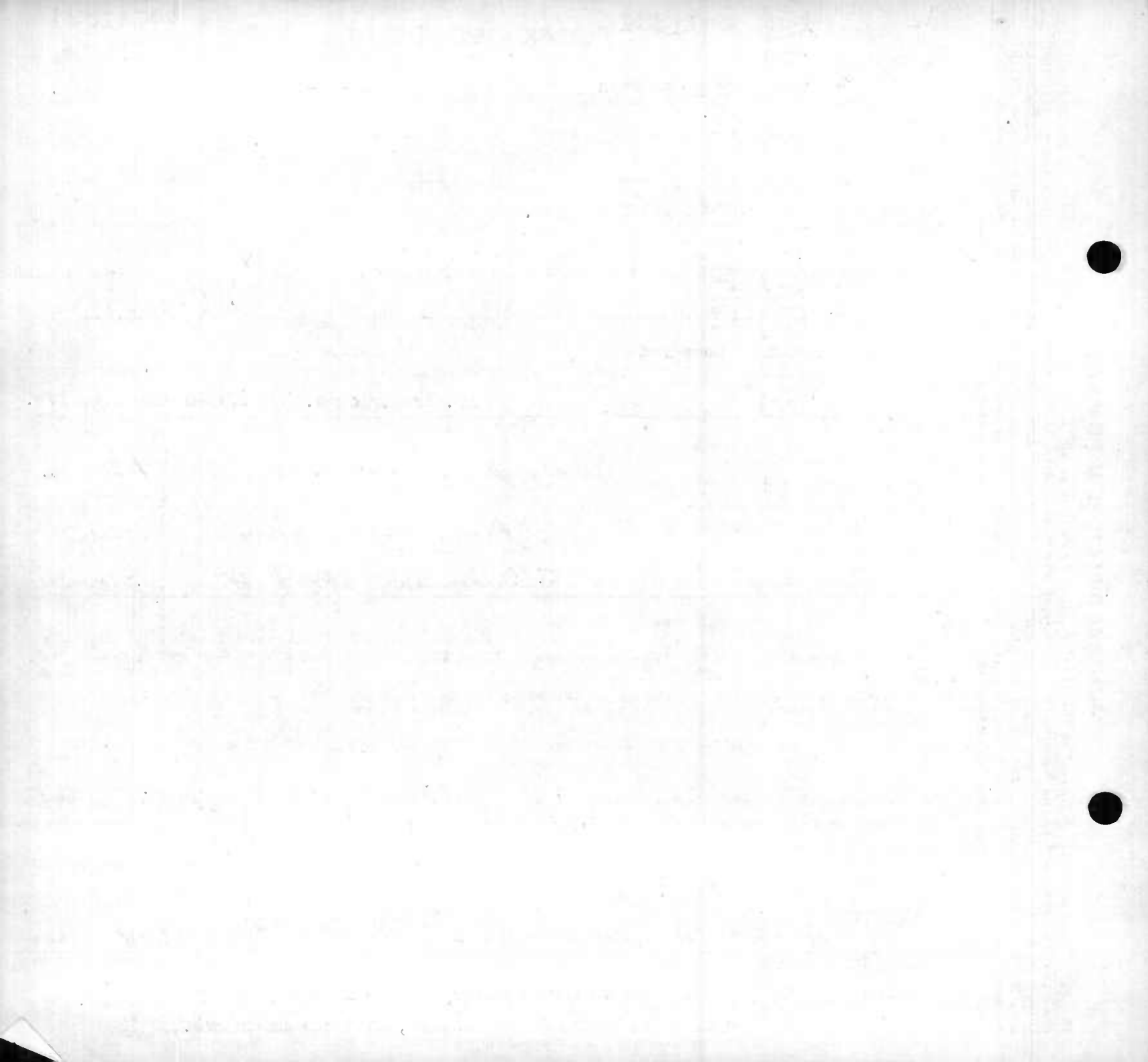
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 68-11993 | |
|--|------------------|---|------------------------------------|--|---|
| 68-11993 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. <i>Balto Co. Md.</i> | | 1. NAME OF DECEASED
(Type or Print) <i>Jill S. Terzano</i> | | 2. DATE AND HOUR OF DEATH
<i>11-28-68</i> <i>9:30</i> A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
<i>7 Mercy Hospital, Inc.</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>8600 Wendell Ave</i> | | | |
| 5. SEX <i>F.</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>5/18/68</i> | 9. AGE (In years last birthday) <i>5 mo.</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, M.D.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>John Joseph Terzano</i> | | 14. MOTHER'S MAIDEN NAME <i>Lois Kalbach</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | | 17. INFORMANT <i>Mother</i> ADDRESS <i>Same as above</i> | |
| 18. <i>349.9</i> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH
<i>Respiratory failure</i>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>pneumonia and upper respiratory infection</i>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<i>adhesion of cervical spinal cord</i>
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>24 hours</i>
<i>12 days</i>
<i>5 months</i> | |
| 19. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11-28-68</i> to <i>11-28-68</i> , that (I) (we) last saw the deceased alive on <i>11-28-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Sang K. Shin, M.D.</i> | | 23B. DATE SIGNED <i>11-28-68</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Sang K. Shin, M.D.</i> | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/2/68</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cem.</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i> | | 24E. NAME OF REGISTRAR <i>Robert E. Indiana</i> | | 24F. FUNERAL DIRECTOR <i>C.F. EVANS & SON</i> | |
| 24G. DATE REC'D BY HEALTH DEPT. <i>DEC 2 1968</i> | | 24H. NAME OF REGISTRAR <i>Robert E. Indiana</i> | | 24I. FUNERAL DIRECTOR <i>C.F. EVANS & SON</i> | |
| 24J. ADDRESS <i>8802 Harford road</i> | | 24K. ADDRESS <i>8802 Harford road</i> | | 24L. ADDRESS <i>8802 Harford road</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

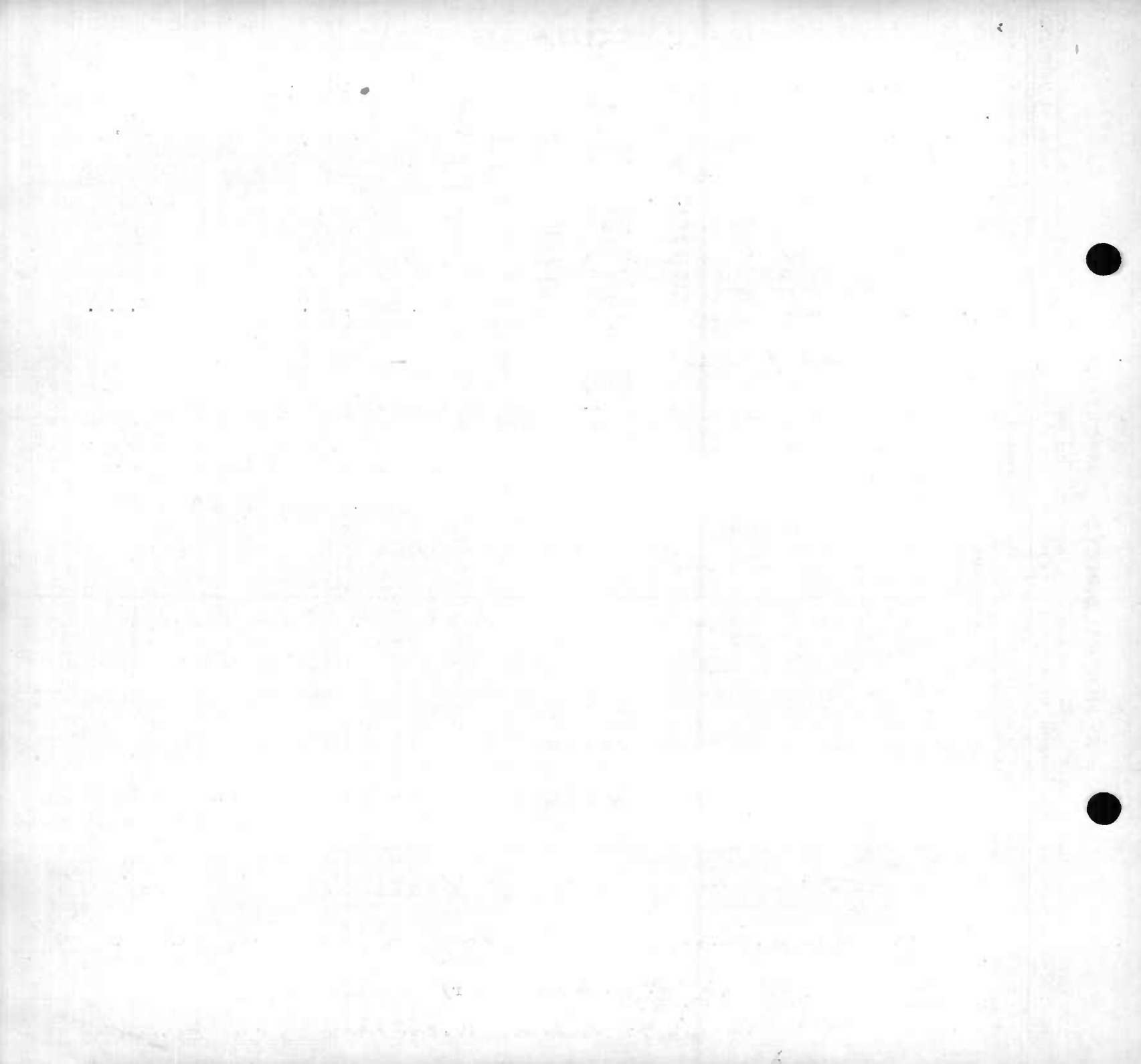
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|------------------|---|-----------------------------|---|---|
| J-523 68-11994 | | | | 68-11994 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| JOHNSON, Agness Johnston | | 11-28-68 2:45 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Bolton Hill Nursing & Convalescent Ctr. | | A. STATE
Maryland | |
| | | | | B. COUNTY | |
| | | | | C. CITY OR TOWN
Baltimore | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
3328 Edmondson Avenue | |
| 5. SEX
F | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-19-79 | 9. AGE (In years last birthday)
88 89 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
John Schmidt deceased | | 14. MOTHER'S MAIDEN NAME
Catherine | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
212-07-5351 | | 17. INFORMANT
Mr. Frederick G. Smoot, 3326 Edmondson Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
440.9 I
Pneumonia | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Chronic brain syndrome | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 years | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
450.0 II | | (B) DUE TO, OR AS A CONSEQUENCE OF:
arteriosclerosis generalized | | years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/2 1968 to 12/28 1968, that (I) (we) last saw the deceased alive on 11/28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Allan H. Machtman | | | | 23B. DATE SIGNED
11/28/68 | |
| 23C. PHYSICIAN'S NAME (Type)
ALLAN H. MACHTMAN | | | | 23D. ADDRESS
2 E. READ ST BALTIMORE 21202 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/2/68 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
DEC 3 1968 | | 25B. NAME OF REGISTRAR
Robert E. Jankins | | 25C. FUNERAL DIRECTOR
Witzke, 4101 Edmondson Ave., 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 68-11995 |
|---|--|--|--|---|----------|
| BIRTH NO. | | 68-11995 | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | M. | |
| ANNA DANKSHO | | 11/28/68 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | |
| 90 Hood Nursing Home | | 5313 Edmondson Ave. | | 249 Holly Beach Rd. Balt Co Md | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| F. | | W. | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Baltimore, Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Dersey Pladis | | | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | | | Raymond C Danksho (Son) | |
| 18. 174 X I | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | Pneumonia and Terminal Phase of Ca. | | Days | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Weeks | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | Months. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 170 X II | | A.S.C.V.D. & Old CVA. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/11/1968 to 11/28/1968, that (I) (we) last saw the deceased alive on 11/28/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Dr. Adnan Sommer | | | | 11/29/1968 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Dr. Adnan Sommer | | | | 1101 Frederick Rd. Balt Co Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/2/68 | | New Cathedral Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 8 1968 | | Robert E. Jackson | | WITKE Funeral Home Edmondson Ave | |
| | | | | 25D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore, Md | |
| | | | | ADDRESS | |
| | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11996 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11996

| | | | | | |
|---|--|---|---|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print)
Catherine Roth | | 2. DATE AND HOUR OF DEATH
28 Nov. 1968 3⁰⁰ A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY 26-01 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
1105 E. Fayette Street | | C. CITY OR TOWN
Baltimore
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX
F | | | 6. RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 8. DATE OF BIRTH
Feb. 4, 1904 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 9. AGE (In years last birthday)
64 | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John DonHouser | | | 14. MOTHER'S MAIDEN NAME
JOSEPHINE BORTHER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
213 01 0491D | | 17. INFORMANT
George Roth 5903 Plumer Ave. |
| 18. CAUSE OF DEATH
25019 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Broncho pneumonia
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Diabetes Mellitus
(B) DUE TO, OR AS A CONSEQUENCE OF:
260X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Acid ammonia (2 days)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3d
several years | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) did not attended the deceased from July 21, 1966 to 28 Nov. 1968 , that (I) do lost saw the deceased alive on 28 Nov. 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did) not view the body after death. | | | | | |
| 23A. SIGNATURE
Jaroslav Hulla M.D. | | | | 23B. DATE SIGNED
28 Nov 68 | |
| 23C. PHYSICIAN'S NAME (Type)
Jaroslav Hulla | | | | 23D. ADDRESS
M.D. 3510 Dudley Ave. Balt Md 21213 | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
BURIAL | | 24B. DATE
11-30-68 | | 24C. NAME OF CEMETERY or CREMATORY
HOLY REDEEMER CEM | |
| 24D. LOCATION
BELAIR RD BAKTO. MD. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 8 1968 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
THE DIPPEN BROTHERS 7110 BELAIR RD | | | |

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1961 . 11

5-363

68-11997 BALTIMORE CITY HEALTH DEPARTMENT

68-11997

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)F.
GEORGE STRAWDER2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ 11 30 68 2:25 a.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital D.O.A.

3. DATE PRONOUNCED DEAD Month Day Year Hour
November 30, 1968 2:25 a.5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE B. COUNTY

Maryland

6. SEX
Male7. RACE
Colored8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN
Balto.D. INSIDE CITY LIMITS?
YES ☐ NO ☐9. DATE OF BIRTH
4/22/4710. AGE (In years last birthday)
21If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

4710 Wakefield Rd.

11. BIRTHPLACE (State or foreign country)
Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
Walter Strawder

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Shipbuilding

15. MOTHER'S MAIDEN NAME

Jessie Collins

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Walter Strawder 538 E. 23rd St.

19. E965X

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Gunshot wound of the chest
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E981X

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Schoolery

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Park Plaza 810 N. Charles

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

11 30 68 2:05

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot during an assault

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/30/68

24A. BURIAL CREMATION, REMOVAL (Specify)
Burial

24B. DATE

12/4/69

24C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 2 1968

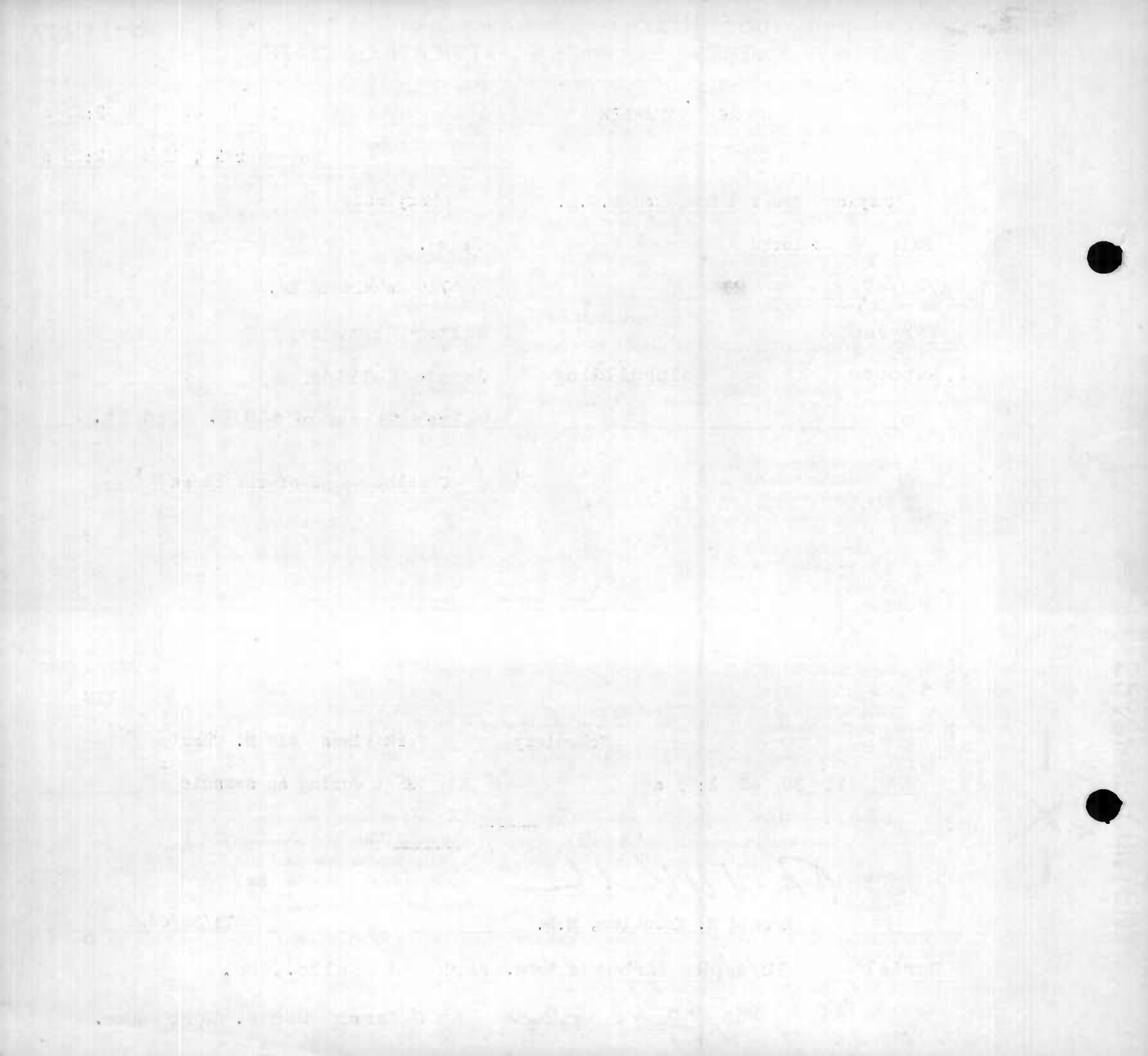
25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

Wm C March 928 E. North Ave.

ADDRESS



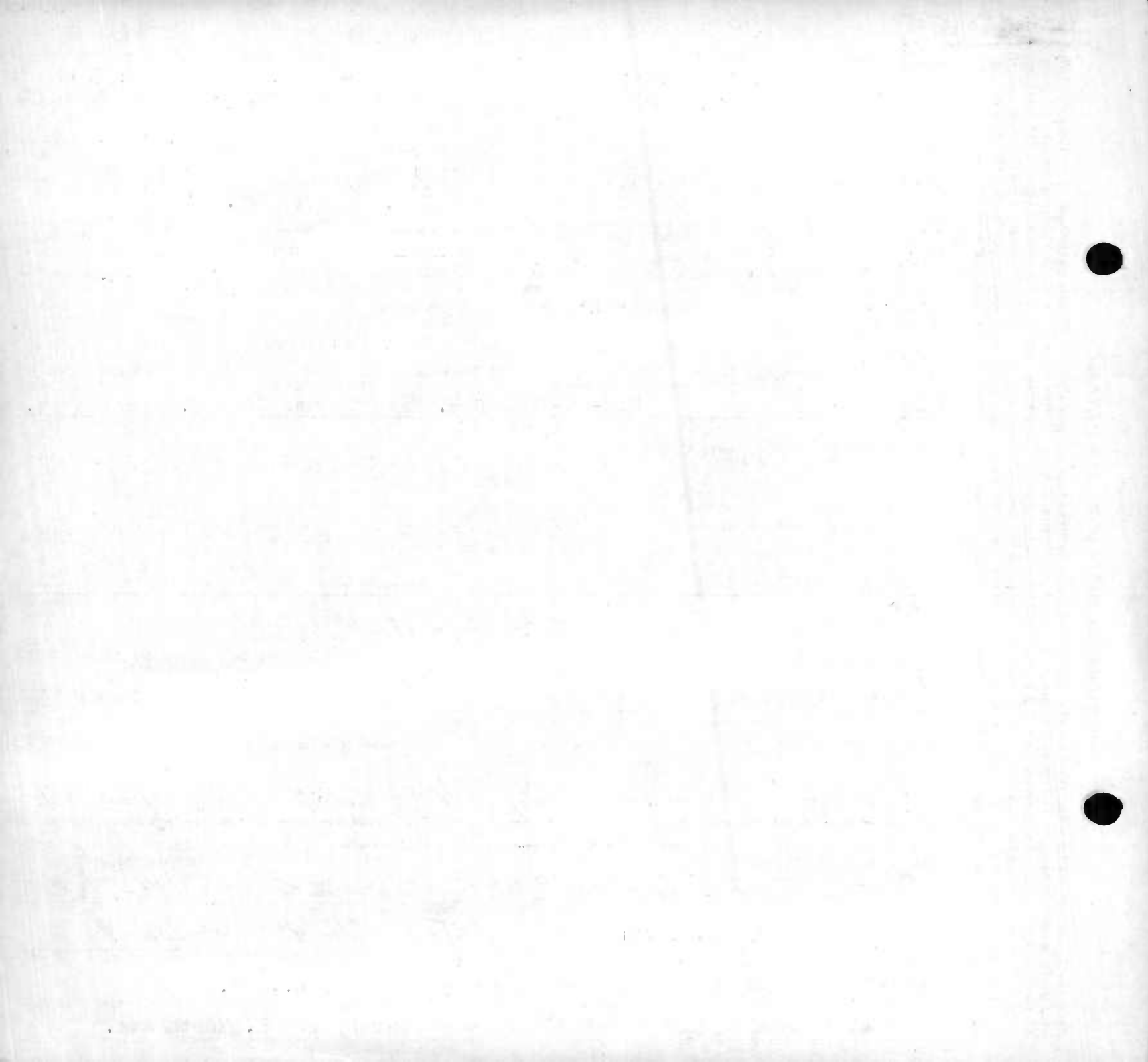
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11998

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11998

| | | | | | |
|--|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) WALTER MATTHEWS | | 2. DATE AND HOUR OF DEATH
11-29-68 4:35 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 803 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
2605 E. PRESTON ST. | | 5. SEX MALE | | 6. RACE NEGRO | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
11-14-68 | | 9. AGE (In years lost birthday) 80 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
MARY MATTHEWS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
318-01-7599 | | 17. INFORMANT
Mrs. Emma Thomas 2605 E. Preston St. | |
| 18. 412.4 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Cerebrovascular Accident 2 mos. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) Dehydration | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (the) (this hospital) attended the deceased from 11/11 1968 to 11/29 1968 , that (I) (we) last saw the deceased alive on 11/29 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joel Engelstein M.D. | | | | 23B. DATE SIGNED
11/29/68 | |
| 23C. PHYSICIAN'S NAME (Type)
JOEL ENGELSTEIN | | | | 23D. ADDRESS
Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/3/68 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Auburn Cemetery | |
| 24D. LOCATION
Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 2 1968 | | 25B. NAME OF REGISTRAR
Robert E. Fairburn | |
| 25C. FUNERAL DIRECTOR
Wm C March | | 25D. ADDRESS
928 E. North Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11999 CERTIFICATE OF DEATH

REG. NO. 68-11999

| | | | | | |
|--|-------------------------|---|---|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) GEORGE J. KNOERLEIN | | 2. DATE AND HOUR OF DEATH
11-28-68 9:54 a.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
35 CHURCH HOME AND HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2418 E. FAYETTE ST. #21224. | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-17-78 | 9. AGE (In years lost birthday)
90 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED, STANDARD OIL CO. | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND, BALTIMORE. |
| 12. CITIZEN OF WHAT COUNTRY?
AMER. | | | 13. FATHER'S NAME
LAWRENCE KNOERLEIN | | |
| 14. MOTHER'S MAIDEN NAME
ANNIE BREHM | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | |
| 16. SOCIAL SECURITY NO.
215-07-1098 | | | 17. INFORMANT
ROBERT B. KNOERLEIN | | |
| 18. 427.21
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Cardiac arrest
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Senile heart
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. 433.0 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-28 1968 to 11-28 1968 , that (I) (we) lost saw the deceased alive on 11-28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
[Signature]
DEGREE | | | | 23B. DATE SIGNED
11-28-68 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. A. E. SUBONG, JR.
DEGREE | | | | 23D. ADDRESS
Church Home & Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
12-2-68, | | 24C. NAME OF CEMETERY or CREMATORY
SACRED HEART CEM. | |
| 24D. LOCATION (City, town, or county) (State)
7401 GERMAN HILL RD, BA. CO., MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
Charles J. Giller | |
| 25D. ADDRESS
901 S. CONKLING ST. BALTO., 21224, MD. | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-12000 CERTIFICATE OF DEATH

REG. NO. 68-12000

| | | | | | |
|---|-------------------------|---|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print)
JOSEPH CLAUDE GORDON | | 2. DATE AND HOUR OF DEATH
NOVEMBER 27, 1968 9:05P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
ST AGNES HOSPITAL
CATON & WILKENS AVES
BALTIMORE MD 21229 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 4621 OLD FREDERICK RD | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
08/08/06 | 9. AGE (In years last birthday)
62 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SUPERINTENDENT | | | 10B. KIND OF BUSINESS OR INDUSTRY
APARTMENTS | | 11. BIRTHPLACE (State or foreign country)
MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY?
U S A | | | 13. FATHER'S NAME
Claude Gordon | | |
| 14. MOTHER'S MAIDEN NAME
JULIA MARTIN | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES WW2 | | |
| 16. SOCIAL SECURITY NO.
212037067 | | | 17. INFORMANT ADDRESS
ST AGNES RECORDS-CATON & WILKENS AVE | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
LIVER Failure
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Cirrhosis of the Liver
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years - | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Bleeding Esophageal Varices | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. HOW DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOV. 4 19 68 to NOV. 27 19 68 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on NOV. 27 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (died) view the body after death. | | | | | |
| 23A. SIGNATURE
Alejandro Mejia
DEGREE | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
ALEJANDRO MEJIA
DEGREE | | | | 23D. ADDRESS
ST AGNES HOSP BALTO MD 21229 | |
| 24A. BURIAL-CREATION, REMOVAL (Specify)
Burial | | 24B. DATE
DEC 2 68 | | 24C. NAME OF CEMETERY or CREMATORY
U. S. National | |
| 24D. LOCATION
Balto. Md. | | 24E. DATE RECEIVED
DEC 2 1968 | | | |
| 25A. NAME OF REGISTRAR
Robert E. Fulkerson | | 25B. FUNERAL DIRECTOR ADDRESS
McCully-130 E. Fort Ave. 21230 | | | |

